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**U.S. ARMY- BAYLOR UNIVERSITY GRADUATE PROGRAM  
IN HEALTHCARE ADMINISTRATION**

**PREDICTABILITY OF REGULAR SOURCE OF HEALTHCARE AND  
PREVENTIVE SERVICES RECEIVED**

**SUBMITTED TO  
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**GRADUATE MANAGEMENT PROJECT (GMP)  
IN PARTIAL FULFILLMENT TOWARD A MASTERS DEGREE IN  
HEALTHCARE ADMINISTRATION**

**WASHINGTON, DC**

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## ABSTRACT

To evaluate several aspects of the Military Health Services System, the Department of Defense, under Congressional mandate, conducted the *1994-1995 Health Care Survey of DoD Beneficiaries*. This paper evaluates the data for a beneficiary's predictability of accessing the MHSS at an appropriate point. Additionally, it analyses a person's predictability of using preventive services.

Current literature had determined that many people receive their routine healthcare from an emergency room. Using this resource as one's regular source of care incurs a considerably higher cost and contributes to longer waiting times. Additionally, it defeats the tenets of using a primary care provider -- continuity of care and appropriate use of healthcare resources.

Preventive care and health promotion have been heralded as one of the best ways to reduce the quantity of healthcare one needs, thus reducing or eliminating the associated cost. It is believed that the use of primary care managers, able to establish a relationship with their patients and provide continuity of care, can increase the rate at which people use these services.

Of the respondents residing in the TRICARE Region 1 area, (n=14398), 8.8 percent lacked a regular source of care. This trait was found to be predictable by service affiliation ( $p<.01$ ), age group, beneficiary group, and marital status ( $p<.001$ ). Contrary to expectations, regular source of care was only predictive of two preventive services, Pap smear ( $p<.05$ ) and mammography ( $p<.01$ ). Use of each of the preventive or promotion services was predictable by two or more of the demographic characteristics.

This study shows that the MHSS must work at educating its population on the use of primary care providers as well as utilization of preventive services available. The TRICARE program's emphasis on both of these issues should improve their use and, in turn, the health of DoD beneficiaries.

## INTRODUCTION

This management project will focus on two aspects of the beneficiaries' ability to access the Military Health Services System (MHSS): first, are they accessing the system through what is normally considered a regular source of care (i.e., a primary care provider or clinic); and second, are they accessing the recommended preventive/health promotion-types of services.

### *Conditions Which Prompted the Study*

The American healthcare industry is going through some very exciting yet turbulent times. It is shifting from "a fragmented cottage industry to an actual healthcare system" (Loeppke 1995). There is a heightened interest in and demand for control of cost, accessibility to the system, and higher quality of care. These demands are being made by the providers, the bill payers, and the recipients of healthcare. Many of these demands are being made because of skyrocketing healthcare expenditures. In 1966, national expenditures for healthcare totaled \$45.9 billion, or 6 percent of the Gross Domestic Product (GDP), the figure topped \$820 billion, 13.9 percent of the GDP, in 1992, and is projected to rise to over \$1.7 trillion (16 percent of the GDP) in the year 2000 (Cherner 1995). The graph at Figure 1 in Appendix 1 demonstrates the growth in healthcare expenditures as a dollar figure and, more importantly, as a percentage of the gross domestic product.

Access to the healthcare system can be defined as broadly as one being able to get to a medical facility and as narrowly as one being able to get the right service where they want it, when they want it. The ability to access the nation's healthcare system varies greatly,

dependent on variables such as geographical location, knowledge of the system, and ability to pay.

The term "quality of care" varies from individual to individual. Some are concerned with the outcome of the treatment they receive ("do I feel better?"); others are concerned with how they are treated ("was the doctor nice?"; "did I have to wait a long time?"); still others look at the quality of the facility itself ("does it have the latest and greatest in medical technology?")

Managed care is one of the methods being used to bring cost, quality, and access under control. The key to managed care is the physicians' willingness to share the financial risk of providing healthcare through capitation. This means that if the physicians incur expenses that exceed the capitated costs, they must absorb all or part of the loss. Conversely, if the expenses of providing care are less than the costs, the physicians share this profit. Under this type of arrangement the physicians have a direct monetary incentive to reduce hospital utilization (Kongstvedt 1995).

One of the key features of any managed care program is that it attempts to ensure that patients enter the healthcare system via an appropriate primary care manager (PCM) and obtain any specialty care only by referral from the PCM. These programs strive to prevent patients from obtaining services that they do not need and incurring expenses that are unnecessary. The capitated budgeting used in most managed care organizations provides a powerful incentive for the provider to find the most cost effective care, treatment, or therapy.

Managed care has attained a dominant position within the US healthcare industry. The number of people enrolled in prepaid health plans in 1973 was about 5 million; today, that number has increased twenty-fold, to about 100 million (Cherner 1995). The graph at Figure



2 at Appendix 1 depicts the increase in available plans as well as the increased number of enrolled lives.

Governmental programs have acknowledged the benefits of using managed care to improving access and quality while controlling cost. With the passage of the Health Maintenance Organization (HMO) Act in 1973, managed care organizations were reimbursed for treating Medicare-eligible patients. Additionally, twenty eight states plus the District of Columbia are currently using some form of managed care in an attempt to contain their Medicaid costs.

The Department of Defense's (DoD) expenditures for health services have risen from about \$1 billion in 1965 (2.1 percent of the Defense budget) to \$12.8 billion (or 14.2 percent of the Defense budget) in 1991. Projections show this figure growing to over \$44 billion (16.8 percent of the Defense budget) in the year 2000 (OMB 1995). Figure 3 at Appendix 1 graphically depicts the National Defense budget and the healthcare programs as a percentage of that budget. The Congress, DoD, and the American people are demanding these expenses be brought under control. The paradigm shift to managed care is manifesting itself within the department in the form of TRICARE. TRICARE is the military managed care initiative in which a contract will be awarded to a bidder on a regional basis. The contractor will offer the military medical beneficiary three alternatives for healthcare, while maintaining the military MTF as the focal point of the program.

The first option, TRICARE Prime, is an HMO-type program. This option assigns the beneficiary a primary care manager (PCM), initially from military providers, then, once these providers have been saturated, from a network set up by the contractor. Beneficiaries choosing to enroll in this option will pay an annual premium but will pay considerably lower

copayments and are not required to meet a deductible. TRICARE Prime will only be available in areas where the contractor's analysis determines that the population can support it. Table 20 shows the benefits and expenses for TRICARE Prime.

The second alternative is TRICARE Extra. This option offers a civilian preferred provider network (PPN), in which the beneficiary can, at his discretion, choose from a government-approved list of healthcare providers. These providers agree to provide their services to the beneficiary at a discounted rate. This option offers the beneficiary more flexibility than TRICARE Prime when it comes to choosing his or her provider. Although the patient must still meet a deductible, they pay less out-of-pocket expenses for treatment, through reduced cost sharing, than they would under the Standard option. See Table 21 for the benefits and costs of TRICARE Extra.

The third option is TRICARE Standard, similar to the current Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the military's indemnity insurance program. Eligibility for this option is the same as for Prime and Extra, with no premium. This program provides the greatest flexibility when it comes to choosing a provider, however, this choice requires the patient to pay a higher cost and meet a higher deductible. Table 21 depicts the benefits and expenses for TRICARE Standard.

Active duty (AD) personnel are automatically enrolled in TRICARE Prime with no premium. All of the options will be available to AD family members, with no premium, as well as retirees and their family members or survivors who are under sixty-five years old, with an annual premium. Due to current legislative mandates, beneficiaries who are eligible for Medicare are not eligible to enroll in TRICARE.

Another feature that has developed as an important piece of managing the patients' care has been prevention. A large percentage of illness and premature death is preventable. Curative medicine involves making an accurate diagnosis and prescribing treatment. Preventive medicine also requires making an accurate diagnosis. However, the diagnosis involves either identifying a patient's high-risk status for an illness that has not yet occurred or diagnosing an asymptomatic disease. Treatment then requires an intervention to forestall or eliminate an illness that might never occur or that might not occur for years (Stange and others 1991). The US Preventive Services Task Force and others have recommended using the medical visit for preventive interventions. Using the PCM in the role of prevention and wellness advisor is key because they should have routine, continuing access to the patients at earlier stages of development of risk factors or diseases.

Studies have determined that, for various reasons, many individuals do not have a regular source of healthcare (Jaen and others 1995; MacKoul and others 1995; Rask and others 1994; Hayward and others 1991). The employment of PCMs by managed care plans is an attempt to rectify this problem. In general, internal medicine physicians, pediatricians, and obstetrical/gynecological physicians are considered primary care physicians. The goal of primary care is to provide first contact care (the patient's entry point into the healthcare system) that should meet four criteria. First, the care is continuous, providing longitudinal, person-focused care over time and across care settings (inpatient and outpatient). Second, it should be comprehensive, offering a range of services broad enough to meet all common needs of the supported population without regard to age, gender, disease, and/or organ system. Third, the care should be coordinated, that being structured in a collaborative, multiple disciplinary team approach, linked in real time to specialty services and information

services. Finally, the care should be accountable, measuring the processes and outcomes to determine best clinical practices, improve patient access and services, and increase staff efficiencies (DoD 1995).

One key aspect of this regular source of care is continuity. The continuity aspect plays directly into the health advisor role of the provider, as previously mentioned. One location that many people define as their source of healthcare is the emergency department (ED) of their local hospital. Those who receive episodic care in the emergency room (ER) may be lacking several key elements of a good overall health program -- continuity of care, well thought out management of their care, preventive measures, and health promotion counseling. Therefore, these individuals are considered as not having a regular source of care.

As the MHSS embarks on their managed care initiative with TRICARE, it would be beneficial to be able to predetermine who are most likely to lack a regular source of routine healthcare, potentially misusing the emergency medical system, as well as those who are not getting recommended preventive services. Identifying and remedying these situations could potentially reduce cost greatly. In an effort to determine to what degree the MHSS is meeting the standards of quality and access, DoD conducts an annual survey of its beneficiaries, the most recent being the *1994-1995 Health Care Survey of DoD Beneficiaries*. This 98 question mail survey was begun in late 1994 and is enclosed at Appendix 5.

#### *Statement of the Research Questions*

This paper investigates two questions surrounding demographics and their ability to predict individuals who lack a regular source of healthcare and those who are not receiving recommended preventive measures:

- RESEARCH QUESTION #1: Can demographic characteristics predict those who lack a “regular source of healthcare”?
- RESEARCH QUESTION #2: Is there a significant correlation between those who lack a “regular source of healthcare”, demographic characteristics, and the preventive or wellness measures one has taken?

Additionally, this project will compare the results of this survey with the stated objectives of the *Healthy People 2000 (HP2K)* initiative. This program is supposed to be the healthcare goal of the United States and a benchmark for the MHSS to compare itself.

The data was derived from the 1994-1995 survey previously mentioned. In order to limit the scope of this study, it focuses on the data from respondents residing in TRICARE Region 1, consisting of Maine, Vermont, New Hampshire, Massachusetts, Connecticut, Rhode Island, New York, New Jersey, Pennsylvania, Delaware, Maryland, District of Columbia, and northern Virginia.

### *The Purpose of the Study*

First, this project will determine if demographics are a significant predictor of those individuals who lack a regular source of healthcare. Identifying a category of individuals who might show an increased likelihood is a key step in the regional market analysis and a point of departure for developing educational programs to prevent this problem. Secondly, since prevention of illness is preferable to treatment, this study will also identify significant

correlation between preventive or wellness measures taken and both (1) demographics and (2) routine source of care. Heightening awareness of and participation in this key aspect of managed care could serve to increase the beneficiary's health and avoid the cost of preventable illness or disease. As highlighted in the literature review portion of this paper, the civilian sector has published reports covering this area of interest. However, the military has not previously considered the predictability of those who lack a regular source of care and its impact on the individual's use of preventive and health promotion services.

## **REVIEW OF THE LITERATURE**

### *Inappropriate Use of Emergency Department Services*

Emergency departments were once considered a source of care for major injuries and life-threatening medical conditions. They have since become a source of primary care and social services for many Americans. As early as the 1950s, it was noted that the number of emergency department visits in the United States was rising dramatically and that many of these visits were for conditions that did not require emergency treatment (Grumbach 1993). Over a five year period, emergency department utilization has increased by 19 percent, from approximately 84 million visits in 1985 to almost 100 million in 1990 (Mitchell 1994). One of the reasons cited for this increase is the higher number of inappropriate categories of patients, those who are nonurgent, who seek care in the emergency departments of hospitals (Mitchell 1994). In fact, according to the National Ambulatory Medical Care Survey, more than half (55.4 percent) of the 89.8 million ED visits, or 49.7 million visits, made in 1992 were for nonurgent care (Baker and Baker 1994). The estimated overall excess charges for these nonurgent treatments were \$7.2 billion (1993 dollars)(Baker and Baker 1994). According to

one study of military beneficiaries, they used the military emergency departments at a "much higher" rate than their civilian counterparts (McMahon 1995). On a smaller scale, a study at a local military community hospital determined that, on average, about 58 percent of patients that signed into the ED were determined to be non-urgent (Hutson 1995).

The definition of "nonurgent" in reference to patient care varies from source to source. A recent General Accounting Office (GAO) report defined nonurgent as "conditions which are neither life- or limb-threatening nor time-sensitive (Nadel 1993). The Centers for Disease Control defined nonurgent as any patient who did "not require attention immediately or within a few hours"(McCaig 1994).

Those patients who seek care for their nonurgent problems in the emergency department create a number of problems, including overcrowded emergency departments, inappropriate utilization of resources, and cost. The cost for a nonurgent patient receiving care in an emergency department setting is considerably more expensive. Like the definition of nonurgent care, different references define "cost" in various, yet significantly contrasting, ways. Cost can be defined as the amount paid by third-party payers. One study determined that the average expenditures for emergency department visits were 80 percent higher than the same diagnoses treated in a physician's office (Gill 1994). When considering the mean first visit charges for all conditions treated at the emergency department versus non-emergency department care, Baker and Baker (1994) found the expense ratio to be 3.37 to 1. The Inspector General of the Department of Health and Human Services has reported that the average charge for a nonurgent, Medicaid patient to be treated in an emergency room was one to five times more expensive when compared to receiving the same treatment in a doctor's office or clinic (Kusserow 1992).

Another definition of cost is the direct cost to the patient -- the out-of-pocket expenses paid by the patient for a certain treatment. Using this definition, while the total charges are usually higher in the emergency department than in the physician's office, the amount paid by the patient is often lower in the emergency room, particularly for patients who have traditional (indemnity) insurance or who are indigent (Gill 1994). However, if one factors in the time aspect of the treatment, on average, care beginning in emergency departments had slightly more visits per episode than those beginning elsewhere (Baker and Baker 1994). This aspect can be further broadened by considering waiting time. In the emergency room at San Francisco General Hospital, situations have arisen in which patients with noncritical conditions waited as long as seventeen hours to be seen and 15 percent of the patients left without ever being seen by a physician (Bindman and others 1991).

A third definition of cost is the expense to the hospital. Generally, the fixed cost of operating an emergency department is high, while the marginal costs are relatively low. This would lead to a decrease in the average cost of treatment as the volume of patients increases. The hospital may see the treatment of nonurgent patients in the emergency room as a means of subsidizing the higher fixed costs of keeping it open and prepared to handle true emergencies (Gill 1994).

Of the studies conducted trying to identify predictors of ED use as a regular source of care, there seems to be one common predictor of those who use the ED instead of more appropriate points of care. Many of the studies have determined that lack of insurance or inability to pay have prompted the significant portion of the sample patients to seek care in the ED (Jaen and others 1995; Rask and others 1994; Baker, Steven and Brooks 1994; Grumbach and others 1993; Hayward and others 1991). This challenge, however, should not be a factor



within the military health services system's beneficiary population, since outpatient treatment at military facilities is provided at no cost to the patient.

Another factor identified by Kellermann (1991) was that the emergency rooms are always open. Unlike clinics or doctor's offices, which may require physician referral or an appointment scheduled weeks or even months in advance, seeking care through the emergency room requires no prior arrangements. Those patients who seek care in the ED may do so in order to avoid waiting on the telephone for appointment scheduling, waiting a long time for the actual appointment, and/or adjusting their schedule to fit that of the clinic's hours of operation.

The American College of Emergency Physicians (1990) has proposed five strategies to alleviate inappropriate emergency department use: (1) Where needed, increase the capacity to provide inpatient, critical care, and nursing home services; (2) Remove financial disincentives to hospitals for providing emergency care; (3) Expand the supply of nurses; (4) Support access to primary care services and encourage initiatives designed to prevent serious illnesses and injuries; and (5) Provide a basic level of health insurance for all citizens.

#### *Lack of Preventive Medicine Practices*

Western medicine has emphasized allopathic, curative medical care since the Flexnor Report of 1910 -- an appropriate approach since acute, infectious diseases were the primary cause of morbidity and mortality. Today, however, the major causes of premature death and morbidity are cardiovascular diseases, cancer, and accidents (Johns and others 1987). About 70 percent of all illness is preventable (Leavenworth 1995a).

In the past, there was no clear delineation of who was the best source for preventive/promotion information. With the advent of managed care, the onus for preventive intervention and advice has been placed on the primary care providers. Lifestyle has long been known to have a direct effect on an individual's morbidity and mortality. A short message by a physician about smoking cessation, for example, has been shown to be successful in inducing 3 to 20 percent of patients to quit smoking (Stange and others 1991).

From 1958 to 1965, a study was conducted that considered the decreased risk of death for California Seventh-Day Adventist church members when compared with other Californians of corresponding age and gender. The Seventh-Day Adventists, renowned for their "pure" lifestyle of abstaining from alcohol, tobacco, and meat, experienced a decreased likelihood of dying from the following conditions than did the control group (Bergman 1977). Table 1 depicts the results of the study.

**Table 1: Results of the Adventist Study**

<b>Causes of Death Directly Related to Smoking</b>	<b>Identified Decrease in Likelihood of Death</b>
Lung Cancer	20%
Mouth, Throat, Larynx Cancer	5%
Bronchitis & Emphysema	32%
Bladder Cancer	28%
<b>Causes of Death Directly Related to Drinking Alcohol</b>	<b>Identified Decrease in Likelihood of Death</b>
Esophageal Cancer	34%
Liver Cirrhosis	13%
Single Vehicle Traffic Accident	54%

Health promotion is “any combination of health education and related organizational, economic, and environmental supports for individual, group, and community behavior conducive to health” (Johns and others 1987). This definition suggests that physicians should involve themselves in: (1) facilitating individual risk reduction (for example, smoking cessation, weight control, etc.) and (2) providing personal preventive health services (e.g., immunizations, mammograms, etc.) among others (Johns and others 1987). The DoD Beneficiary Survey addresses these two areas.

Attempts at providing preventive and wellness care within the emergency department have met with very limited success. In one study, 30 percent of women receiving a Pap smear in the ED which returned abnormal results could not be reached for follow-up testing, counseling, and/or treatment (Hogness and others 1992). This is due, at least in part, to the lack of continuity of care for those using the ED as their regular source of care.

When resources were allocated to the ED for immunizations, only 41 percent of children received measles vaccines (Lindegren and others 1993) and only 37 percent of eligible adults received pneumococcal immunizations (Polis and others 1988). Once again, the ED physician, having only an acute, episodic relationship with the patients, does not know his or her immunization history, therefore the doctor is not cognizant of the shortcomings. Also, many physicians are reluctant to immunize an individual when they are suffering from another illness or condition.

It has actually been suggested that most preventive services do not provide a cost benefit. Some believe that prevention is “not going to save money, it’s going to cost; It may be a cost-effective way to save lives, but it doesn’t really save money” (Jones 1995). According to a recent review of available data, it was reported that of all the preventive

services evaluated, only three paid for themselves in the end: prenatal care for poor women, tests in newborns for some congenital disorders, and most childhood immunizations. When one only considers the monetary cost of medicine, a surprising “rip off” is high blood pressure screening. Although this test is cheap, and treating high blood pressure helps many people avoid heart attacks, strokes, and other expensive conditions, the cost-effectiveness varies considerably. It costs far less to add a healthy year of life by screening 60-year-olds than by screening younger individual. So, too, monitoring of any age group buys less health for the females than for the males, who more often suffer from hypertension (Leutwyler 1995).

Others believe that prevention strategies do pay off. Stratus Computers in Marlboro, Massachusetts reduced the need for costly blood pressure- and lipid-lowering medications for their employees through a heart-disease risk-reduction program. They estimate to have saved \$50,000 in prescription costs alone, and that does not count the cost of hospitalization, procedures, and work loss that might have resulted had these risk factors not decreased (Leavenworth 1995b).

### *Healthy People 2000*

In 1990, the US Department of Health and Human Services (DHHS) developed the *HP2K* program. The central challenge of this program is to implement what is already known about promoting health and preventing disease. The purpose of the program is to commit the Nation to the attainment of three broad goals: (1) to increase the span of healthy life for Americans; (2) to reduce health disparities among Americans; and (3) to achieve access to preventive services for all Americans (DHHS 1990).

This program was developed , in part, because of the increasing economic burden of preventable illness, injury, and disability. Coronary artery disease affects approximately 7 million Americans and causes 1.5 million heart attacks and 500,000 deaths a year. The number of coronary bypass procedures performed each year is approaching 300,000, each one of these procedures at a cost of approximately \$30,000. A representative cost for treating a single case of lung cancer is \$29,000 and \$28,000 for invasive cervical cancer. A liver transplant for alcoholic cirrhosis can cost \$250,000 or more. The lifetime treatment costs per patient are \$354,000 for congenital rubella syndrome (DHHS 1990). Yet virtually all of these conditions are preventable. It is economically imperative that the Nation mobilize its energies and creativity in the interest of disease prevention and health promotion.

This program set national objectives for a wide variety of health promotion strategies, health protection strategies, and preventive services. DHHS defined the health promotion strategies as those related to individual lifestyle -- personal choices made in a social context -- that can have powerful influence over one's health prospects (DHHS 1990). Health protection strategies are those related environmental or regulatory measures that confer protection on large population groups. Preventive services include counseling, screening, immunizations, or chemoprophylactic interventions for individuals in clinical settings.

The preventive health and wellness promotion items covered in the DoD Beneficiary Survey were a subset of the objectives identified in *HP2K*. Table 22 in Appendix 3 displays a list of the *HP2K* objectives that overlap with the interests of the DoD's survey questions surrounding preventive and wellness services.

## METHODS AND PROCEDURES

### *Background of the Survey*

The Defense Authorization Act for Fiscal Year (FY) 1993 (Public Law 102-484) mandated that the Secretary of Defense conduct an annual formal survey of persons receiving healthcare under chapter 5 of title 10, United States Code (USC), in order to determine the following:

- The availability of healthcare services to authorized beneficiaries through the military health services direct care system, the types of services received, and the facilities in which the services are provided;
- The familiarity of the beneficiary with the services available within the MHSS and with the facilities in which the services are provided;
- The health of the beneficiary population;
- The level of satisfaction with the MHSS and the quality of the healthcare provided through the system; and
- Any other matters as the Secretary determines appropriate.

The Annual Health Care Survey of Department of Defense (DoD) Beneficiaries was designed to provide information which would be used for three primary purposes (DoD 1994):

1. Policy Compliance and Development. This survey met the requirements of the aforementioned section of the Authorization Act and permits DoD to develop broad policy initiatives based on the analysis of the data.
2. Regional Performance Evaluation. The survey can be used to collect information from individuals in each of the catchment areas, and expanded out to the TRICARE regional level, in order to monitor variations in quality throughout the

military healthcare system. This information includes measures of access, satisfaction, and health status.

3. Local Catchment Commander/Lead Agents. At the local and regional levels, leaders can use the survey data for market analysis and to identify areas for continuous quality improvement. The local and regional information is most valuable because this is the level where perceived satisfaction has direct impact on enrollment choices in healthcare plans.

In accordance with the Congressional mandate and requirements identified by DoD, the survey asked respondents questions designed to obtain the following information:

- Access - Questions on access to medical care measure the degree of accessibility to healthcare. The survey instrument measured the perceived range of choice over alternative sources, point of entry into the system, degree of preventive services available, and measures of convenience in time and distance, waiting time, and appointment alternatives. Many of these issues contribute to the patients perceived quality of care.
- Familiarity - Questions on familiarity ask whether beneficiaries have a source of information concerning various aspects of their health benefit. Familiarity with the health benefit may influence access to, use of, and perceived quality of the MHSS.
- Health Status - Questions on health status provide general measures of lost duty time, well being, fatigue/energy, and physical and emotional health. Health status influences demand on healthcare and could be used to analyze levels of utilization, access, and quality.
- Satisfaction - Questions on satisfaction include satisfaction with provider behavior, facilities, satisfaction with specific aspects of healthcare, and overall satisfaction with the military healthcare benefit.

- Utilization - Questions on utilization measure the relative and comparative use of the military treatment facility and healthcare alternatives available to the respondent in terms of annual visits, admissions, and source of care. This survey also looks at the beneficiary's normal source for routine healthcare.
- Demographics - Questions in this section include standard demographic information, such as age, gender, race/ethnicity, that are needed for statistical analysis. Questions in this section also include beneficiary category, education level, location, and other related variables.

In developing this survey instrument, DoD reviewed existing survey efforts to determine if the information was already available or in the planning stages. The Annual Health Care Survey for DoD Beneficiaries had replaced existing beneficiary surveys being conducted in the Army and Air Force. The 1992 DoD Survey of Military Medical Beneficiaries (also known as "the Section 733 Study Survey") was a one-time effort, and thus will not compete with this survey. This survey did not duplicate the information collection efforts of any other agency or component.

### *Sampling Procedures*

The data for this study was drawn from the *1994-1995 Health Care Survey of DoD Beneficiaries*. The population for this survey was all persons over 18 years of age and eligible for care at DoD treatment facilities who were enrolled in the Defense Enrollment Eligibility Reporting System (DEERS) as of August 10, 1994. The population size (N) was 6,592,033. The contracted survey organization, Westat, Incorporated of Rockville, Maryland, conducted



the survey. They conducted a complex probability sampling in accordance with the DoD defined stratification of the sample by catchment area (161 possible) and by beneficiary group (6 possible) as one of the criterion. This requirement yielded 966 potential sampling strata. Considering the precision requirements dictated to the contractor by DoD, an "optimal" stratified sample size of  $n = 166,000$  was required, designed to yield 97,000 completed surveys.

In January 1995, the survey instrument was mailed out to 165,952 selected active duty members, their dependents/survivors, retirees, and dependents/survivors of retirees. It was estimated that each respondent would spend an average of thirty minutes filling out the survey instrument. All respondents were provided a postage-paid Business Reply Envelope to return the survey. Each sample member was mailed a reminder post card two weeks after they were mailed the survey.

All nonrespondents were sent a second survey with a prompting letter six to eight weeks after initial mailout. Of those beneficiaries surveyed approximately 88,511, or about 53 percent of the original mailing list, completed and returned their questionnaire. A telephonic follow-up survey was conducted of those persons whose surveys were not returned. The relative low response rate can be attributed, in part, to 12 percent of the surveys being returned by the Postal Service as undeliverable. Other individuals simply stated that they chose not to participate.

### *Goals of the Survey*

The goals of the analysis of the received data were stated in the supporting statement provided by the Assistant Secretary of Defense (Health Affairs) to the Office of Manpower

and Budgeting (OMB). The first goal was to meet the requirements set forth by Congress in Section 724 of the FY 1993 Defense Authorization Act and provide overall descriptive statistical information. Additionally, this document stipulated:

“Where appropriate, multivariate analyses will be conducted to examine the relationship between demographic variables, health status, satisfaction, utilization, access, and familiarity. This may include the examination of the interaction between satisfaction and beneficiary category, type of healthcare used, and demographic characteristics. Other multivariate analyses to be considered are the interactions between access to care and beneficiary category, type of healthcare used, health status, and demographic characteristics.

The second goal of the analysis is to provide information at the catchment area and clinic level which will focus on the quality of service. The Program Review and Evaluation Directorate will provide the direction for the analyses. A report will be provided to each catchment area commander and clinic commander which will be used for market analysis and for the identification of areas of patient care and services which need improvement. The data will be weighted to provide accurate catchment area estimates for each commander. Analyses will be consistent across all catchment areas and reported in a manner so that standardized comparisons across areas can be made. The margin of error for each catchment area, based on the current sampling plan, is expected to be plus or minus five percent.” (DoD 1994)

This data has been made available to each service to conduct analysis specific to their level of management. OASD(HA) believes that this information will be most useful when examined on the regional level. For these aforementioned reasons, this project conducts analyses for the data received from the Region 1 survey participants.

### *Operational Definitions*

**SOURCE OF HEALTHCARE.** The source of healthcare is based on the subject's response to question 1. An individual was categorized as having no regular source of care if they answered “I do not have a usual source of care” or “Don't know what kind of place.”

Additionally, since regular source of healthcare can be characterized by maintaining some type of continuity of care for the patient, those who responded that they use either a military or civilian emergency room were considered as not having a regular source of care.

**DEMOGRAPHIC CHARACTERISTICS.** The demographic characteristics used in this project include gender, beneficiary category, service affiliation, marital status, education level, and race/ethnicity. All variables were mutually exclusive and categorically exhaustive. Definitions of these different characteristics are described in Table 2 on the next page. This data was drawn from the questions contained in Section IV, Information About You, except for question 84; the questions that were not used were 95 and 97.

**PREVENTIVE SERVICES.** The preventive services, which incorporates several health promotion services, consist of whether or not the individual received the service within the last twelve months. Respondents who answered “no” to the questions had the opportunity to subcategorize their response into one of the following three areas: (1) “I tried but could not get the service”; (2) “it was needed but I did not try to get it”; or (3) “it was not needed.”

The survey inquired about the following services: general medical examination, blood pressure check, cholesterol screening, wellness screening, immunizations, dental exam, smoking cessation, weight control, Pap smear, mammography, and prostate exam. The data for this portion of the study was taken from questions 4a through 4k.

### *Analysis*

The statistical analyses were performed using the SPSS (Statistical Package for Social Sciences), version 6.1.3. The analyses were divided into two stages. During the first stage, potential demographic predictors were compared with the trait of “no regular source of

**Table 2: Demographic Variable Definitions**

VARIABLE	QUESTION	DEFINITION
AGE	87	Age of the respondent on their most recent birthday. Individuals are categorized as follows: younger than 20 (1); 20-29 (2); 30-39 (3); 40-49 (4); 50-64 (5), 65 and older (6).
GENDER	84	Gender is defined as female (0) or male (1).
BENEFICIARY CATEGORY	88a 89a 90	Military status in this report pertains to the duty status of the eligible beneficiary. Respondents fell into one of four categories: Members on active duty (AD)(1), family members (including survivors) of active duty (ADFM)(2), retirees (any form of military retirement in which medical benefits were included)(3), and family members of retirees (RFM)(4).
SERVICE AFFILIATION	88b 89b	This variable places the respondent into one of four service categories: Army (USA)(1), Air Force (USAF)(2), Navy and Marine Corps (USN)(3), and others beneficiary services, such as National Oceanic and Atmospheric Administration, Public Health Service, and Coast Guard (OTHERS)(4), based on the individual or the individual's sponsor affiliation.
MARITAL STATUS	91	Marital status categories presented in this study are "never married"(1), "married"(2), "separated/divorced"(3), and "widowed"(4).
EDUCATION LEVEL	92	Education level refers to the highest level of education attained based on the schooling or degree received. The "less than college degree"(1) category is made up of those with some college but no degree, high school diploma, high school equivalency, or no high school diploma. "College degree"(2) includes associate's and bachelor's degrees, and "More than college" is made up of those with any education above the BA/BS level.
RACE/ ETHNICITY	93 94	Following the current US Bureau of the Census classifications, personnel were grouped into four racial/ethnic groups. Personnel referred to as "white"(1) are those who responded that they are "white," but "not of Hispanic/Spanish origin." Personnel categorized as "black"(2) are those individuals who responded as being "black," but "not of Hispanic/Spanish origin." "Hispanic"(3) includes anyone of Hispanic origin - whether racially white, black, or other. The category "other"(4) consists of all other persons not elsewhere classified (i.e., Native American Indian, Eskimo, Aleutian, Asian, or Pacific Islander).

healthcare" using Pearson's chi-square tests, with the alpha level initially set at .05. In the second stage, the same demographic variables plus the variable for source of care were examined and compared with the preventive services taken using the chi-square test, again setting the alpha level at .05 for statistical significance.

### *Validity and Reliability*

The validity of the survey instrument was established by conducting two pretests on random members of the population. After completing the pretest, the surveyors sat down with those surveyed and discussed each question to ensure they were worded correctly. They also ensured that the respondents were interpreting the questions as they were intended. Gilbert, Longmate, and Branch (1992) raised question as to the reliability of mail-out survey. Although they did not find significant problems, they described several biases one needs to be wary of when examining this type of survey. For the purpose of this study, it is assumed that the survey instrument is both valid and reliable.

### *Ethical Considerations*

The confidentiality of the survey is assured by the Privacy Act statement. The respondents were informed that all answers to the survey would be kept confidential and that under no circumstances would any information about individuals be released; only group statistics would be reported. The Defense Manpower Data Center has established procedures for survey storage and disposal which ensure that individual identifiers do not appear in any analytical data set. For purposes of this study, this researcher will be granted access to all data from the survey with all identifying variables removed from the data base.

In the original proposal for this project, another demographic category was to be considered -- pay grade. This variable was omitted from the available data base due to concerns that, in combination with the other demographic variables, it could identify the respondents.

## FINDINGS AND DISCUSSION

### *Descriptive Statistics*

The surveys mailed out to the eligible beneficiaries yielded 14,398 responses. However, the number of valid responses fluctuates from variable to variable due to incomplete, improper, or illegible responses. Any response coded as “missing” was not used in the analysis for the variables for which it was missing. The demographic information for the respondents is contained in Table 3.

For the “Regular Source of Healthcare” variable, 1274 persons ( 8.8 percent) provided responses that were categorized as having no regular source. These responses could have been either “Military emergency room”, “Civilian emergency room”, “I don’t have a regular source of care”, or “Don’t know”. Table 4 reports the demographic variables and the significance of their ability to predict whether an individual has a regular healthcare source. Service Affiliation demonstrated a significant ability to predict whether an individual had a regular source of care at the 99.2 percent confidence level. Three of the variables (Age, Beneficiary Group, and Marital Status) exceeded the 99.9 percent confidence interval for predictability.

Tables 5 through 15 show the demographic variables when compared to the eleven preventive service variables surveyed. The additional variable of “Regular Source of Care” was also considered when looking into whether or not an individual had received the prescribed battery of preventive and wellness services.

**Table 3: Demographics of the Region 1 Respondents**

<b>Variable</b>	<b>n</b>	<b>% of Total</b>
<i>Gender</i>	14355	
• Females	6930	48.3
• Males	7425	51.7
<i>Service Affiliation</i>	13465	
• Army	4277	31.8
• Air Force	4102	30.5
• Navy/USMC	4263	31.7
• Other	823	6.1
<i>Race/Ethnicity</i>	12347	
• White	10272	83.2
• Black	1095	8.9
• Hispanic	373	3.0
• Other	607	4.9
<i>Age</i>	12276	
• < 20	605	4.3
• 20 - 29	1453	10.4
• 30 - 39	1932	13.8
• 40 - 49	2101	15.0
• 50 - 64	3179	22.7
• > 65	4732	33.8
<i>Beneficiary Group</i>	14398	
• Active Duty (AD)	2112	14.7
• AD Family Member	2266	15.7
• Retired	5464	37.9
• Retired Family Member	4556	31.6
<i>Education Level</i>	12276	
• < College Degree	6788	55.3
• College Degree	2598	21.2
• > College Education	2890	23.5
<i>Marital Status</i>	14144	
• Not Married	961	6.8
• Married	11113	78.6
• Separated/Divorced	765	5.4
• Widowed	1305	9.2

**Table 4: Predictability of Regular Source of Care**

Variable	Regular Source of Healthcare	No Regular Source of Healthcare	Without Regular Source (%)	Invalid Responses	df	Chi Square	p
<i>Gender</i>							
• Females	6307	623	8.8	43	1	.337	.561
• Males	6779	646	+ 9.0 8.7				
<i>Service Affiliation</i>							
• Army	3888	389	8.7	933	3	11.728	.008
• Air Force	3794	308	9.1				*
• Navy/USMC	3881	382	7.5				
• Other	737	86	9.0 + 10.4				
<i>Race/Ethnicity</i>							
• White	9340	932	9.1	2051	3	1.237	.744
• Black	990	105	9.1				
• Hispanic	337	36	9.6				
• Other	558	49	9.7 + 8.1				
<i>Age</i>							
• < 20	523	82	8.8	396	5	56.509	.000
• 20 - 29	1326	127	+ 6.6				**
• 30 - 39	1800	132	8.7				
• 40 - 49	1946	155	6.8				
• 50 - 64	2938	241	7.4				
• > 65	4230	502	7.6 10.6				
<i>Beneficiary Group</i>							
• Active Duty (AD)	2000	112	8.8	0	3	41.624	.000
• AD Family Member	2073	193	+ 5.3				**
• Retired	4935	529	8.5				
• Retired Family Member	4116	440	9.7 9.7				
<i>Education Level</i>							
• < College Degree	6183	605	9.0	2122	2	.294	.864
• College Degree	2361	237	8.9				
• > College Education	2623	267	9.1 + 9.2				
<i>Marital Status</i>							
• Not Married	871	90	8.8	254	3	35.433	.000
• Married	10175	938	9.4				**
• Separated/Divorced	714	51	8.4				
• Widowed	1135	170	6.7 + 13.0				

+ denotes most significant cause of difference within each variable

\* denotes significance of  $p < .01$ \*\* denotes significance of  $p < .001$



**Table 5: Significant Predictors of Blood Pressure Check**

Variable	n	No Blood Pressure (%)	df	Chi Square	Tried But Could Not Get The Service (%)	Did Not Try To Get The Service (%)	Did Not Need The Service (%) (Self Reported)
<i>Service Affiliation</i>	11267	13.9	3	8.819	4.0	17.9	78.1
• Army	478	13.3		*	3.9	18.1	78.0
• Air Force	493	14.1			4.5	15.6	79.9
• Navy/USMC	477	13.7			3.8	20.0	76.3
• Other	121	+ 17.5			4.0	17.7	78.2
<i>Race/Ethnicity</i>	11832	13.9	3	28.126	4.3	17.8	77.9
• White	1362	13.7		***	3.9	18.1	78.1
• Black	131	12.5			6.8	17.7	75.5
• Hispanic	26	10.7			3.4	6.9	89.7
• Other	120	+ 20.9			7.0	17.1	76.0
<i>Education Level</i>	11877	13.9	2	12.961 **	4.3	17.8	77.8
• < College Degree	6532	14.7			4.0	16.7	79.3
• College Degree	2526	14.3			5.0	18.1	76.9
• > College Education	2819	+ 11.9			4.5	20.8	74.6

**Table 6: Significant Predictors of Pap Smear**

Variable	n	No Pap Smear (%)	df	Chi Square	Tried But Could Not Get The Service (%)	Did Not Try To Get The Service (%)	Did Not Need The Service (%) (Self Reported)
<i>Education Level</i>	3247	32.6	2	25.196	13.3	37.5	49.2
• < College Degree	1985	35.9		***	12.1	36.5	51.4
• College Degree	745	+ 26.4			16.7	41.1	42.2
• > College Education	517	29.2			14.4	37.1	48.5
<i>Regular Source of Care</i>	3297	32.7	1	4.778	13.3	37.0	49.7
• Yes	3003	32.2		*	13.5	37.2	49.4
• No	294	+ 38.4			12.1	35.4	52.5

+ denotes most significant cause of difference within each variable

\* denotes significance of  $p < .05$

\*\* denotes significance of  $p < .01$

\*\*\* denotes significance of  $p < .001$

Table 7: Significant Predictors of Cholesterol Screening

Variable	n	No Cholesterol Check (%)	df	Chi Square	Tried But Could Not Get The Service (%)	Did Not Try To Get The Service (%)	Did Not Need The Service (%) (Self Reported)
<i>Service Affiliation</i>	10795	39.3	3	12.417	4.5	22.8	72.6
• Army	3440	38.7		**	4.5	21.6	73.9
• Air Force	3359	39.2			4.4	22.5	73.1
• Navy/USMC	3329	38.8			4.5	24.5	71.0
• Other	667	+ 45.7			5.3	22.3	72.4
<i>Race/Ethnicity</i>	11832	13.9	3	28.126	4.3	17.8	77.9
• White	1362	13.7		***	3.9	18.1	78.1
• Black	131	12.5			6.8	17.7	75.5
• Hispanic	26	10.7			3.4	6.9	89.7
• Other	120	+ 20.9			7.0	17.1	76.0
<i>Age</i>	11198	39.5	5	34.903	4.6	23.0	72.5
• < 20	457	41.8		***	5.9	25.1	69.0
• 20 - 29	1147	+ 45.2			2.7	22.6	74.7
• 30 - 39	1503	42.2			4.5	20.7	74.8
• 40 - 49	1622	40.4			4.4	25.8	69.7
• 50 - 64	2641	38.3			4.6	26.2	69.2
• > 65	3828	36.8			5.1	20.3	74.6
<i>Beneficiary Group</i>	11523	39.4	3	37.380	4.6	22.9	72.4
• Active Duty (AD)	1609	39.2		***	4.0	21.7	74.2
• AD Family Member	1764	+ 45.8			3.9	22.6	73.6
• Retired (RET)	4480	38.3			5.7	24.3	70.0
• RET Family Member	3670	37.6			4.0	22.0	74.0
<i>Education Level</i>	11369	39.5	2	29.677	4.6	23.0	72.4
• < College Degree	6222	40.2		***	4.2	20.0	75.8
• College Degree	2406	42.5			4.8	24.5	70.7
• > College Education	2741	+ 35.4			5.6	29.0	65.5
<i>Marital Status</i>	11340	39.4	3	8.871	4.6	22.9	72.6
• Not Married	772	42.4		*	4.3	21.8	73.8
• Married	8917	39.7			4.4	23.4	72.2
• Separated/Divorced	582	38.1			6.9	22.5	70.6
• Widowed	1069	+ 35.9			5.1	19.4	75.5

+ denotes most significant cause of difference within each variable

\* denotes significance of  $p < .05$ \*\* denotes significance of  $p < .01$ \*\*\* denotes significance of  $p < .001$

**Table 8: Significant Predictors of Dental Examination**

Variable	n	No Dental Exam (%)	df	Chi Square	Tried But Could Not Get The Service (%)	Did Not Try To Get The Service (%)	Did Not Need The Service (%) (Self Reported)
<i>Race/Ethnicity</i>	11383	37.0	6	42.755	31.0	28.7	40.3
• White	9621	36.2		***	28.9	28.8	42.3
• Black	956	+ 42.7			45.2	27.6	27.2
• Hispanic	237	36.3			23.3	34.9	41.9
• Other	569	40.4			38.7	27.3	34.0
<i>Beneficiary Group</i>	11582	37.0	6	13.188 *	31.0	28.7	40.3
• Active Duty (AD)	1613	+ 33.5			33.5	28.1	38.4
• AD Family Member	1768	37.3			30.0	29.1	41.0
• Retired (RET)	4517	37.4			31.8	28.9	39.3
• RET Family Member	3684	37.9			29.7	28.4	41.9
<i>Education Level</i>	11431	36.9	4	278.556	31.1	28.8	40.1
• < College Degree	6218	43.5		***	28.1	26.0	45.9
• College Degree	2463	31.8			35.4	32.1	32.5
• > College Education	2750	+ 26.5			37.4	35.0	27.6

**Table 9: Significant Predictors of Weight Control Counseling**

Variable	n	No Weight Control Counseling (%)	df	Chi Square	Tried But Could Not Get The Service (%)	Did Not Try To Get The Service (%)	Did Not Need The Service (%) (Self Reported)
<i>Race/Ethnicity</i>	11229	84.5	6	48.636	1.4	12.8	85.8
• White	9457	84.9		***	1.3	12.9	85.8
• Black	983	+ 78.0			2.2	14.9	82.9
• Hispanic	235	86.0			1.5	8.0	90.5
• Other	554	88.4			1.6	9.9	88.5
<i>Education Level</i>	11274	84.6	4	88.814	1.4	12.9	85.7
• < College Degree	6188	81.7		***	1.7	13.1	85.2
• College Degree	2404	87.3			1.0	13.4	85.6
• > College Education	2682	+ 88.7			1.1	12.0	86.9

+ denotes most significant cause of difference within each variable

\* denotes significance of  $p < .05$

\*\* denotes significance of  $p < .01$

\*\*\* denotes significance of  $p < .001$

Table 10: Significant Predictors of Immunizations

Variable	n	No Immunization (%)	df	Chi Square	Tried But Could Not Get The Service (%)	Did Not Try To Get The Service (%)	Did Not Need The Service (%) (Self Reported)
<i>Race/Ethnicity</i>	11491	49.7	6	20.112	2.0	8.0	90.1
• White	9701	49.3		**	1.8	7.7	90.5
• Black	991	51.1			2.1	10.2	87.7
• Hispanic	239	46.0			2.8	5.6	91.7
• Other	560	+ 55.5			4.1	9.1	86.8
<i>Age</i>	11358	49.6	10	19.069	2.0	8.0	90.0
• < 20	477	49.9		*	4.3	6.9	88.8
• 20 - 29	1170	50.1			0.9	8.7	90.4
• 30 - 39	1536	50.2			1.6	7.5	90.8
• 40 - 49	1640	52.0			2.3	6.9	90.8
• 50 - 64	2652	51.3			2.0	7.8	90.2
• > 65	3883	+ 47.1			2.0	8.8	89.2
<i>Education Level</i>	11540	49.6	4	33.278	2.0	8.0	90.0
• < College Degree	6357	50.4		***	2.1	7.6	90.3
• College Degree	2444	51.1			1.9	7.7	90.4
• > College Education	2739	+ 46.4			1.9	9.0	89.1
<i>Marital Status</i>	11492	49.6	6	14.017	2.0	7.9	90.1
• Not Married	784	47.6		*	2.5	7.7	89.8
• Married	9041	50.4			1.9	8.1	90.0
• Separated/Divorced	589	47.4			2.9	7.7	89.4
• Widowed	1078	+ 46.0			1.6	6.6	91.8

+ denotes most significant cause of difference within each variable

\* denotes significance of  $p < .05$ \*\* denotes significance of  $p < .01$ \*\*\* denotes significance of  $p < .001$

Table 11: Significant Predictors of Mammography

Variable	n	Lacking A Mammogram (%)	df	Chi Square	Tried But Could Not Get The Service (%)	Did Not Try To Get The Service (%)	Did Not Need The Service (%) (Self Reported)
<i>Race/Ethnicity</i>	3226	46.7	3	28.675	7.5	19.5	72.9
• White	2757	44.9		***	7.1	19.5	73.4
• Black	225	53.8			8.6	21.0	70.5
• Hispanic	75	50.7			5.7	8.6	85.7
• Other	169	+ 63.9			11.8	22.5	65.7
<i>Age</i>	3200	46.4	5	67.765	7.4	19.4	73.3
• < 20	168	48.8		***	5.6	16.9	77.5
• 20 - 29	372	+ 61.3			7.0	13.0	80.0
• 30 - 39	518	54.1			5.0	19.6	75.4
• 40 - 49	465	45.4			8.7	23.0	68.4
• 50 - 64	612	40.2			10.1	22.4	67.5
• > 65	1054	41.0			7.2	19.5	73.3
<i>Beneficiary Group</i>	3281	46.6	3	52.509	7.5	19.4	73.1
• Active Duty (AD)	139	46.0		***	1.6	13.1	85.2
• AD Family Member	958	+ 56.3			7.8	18.5	73.8
• Retired (RET)	57	+ 36.8			18.8	25.0	56.3
• RET Family Member	2127	42.5			7.6	20.2	72.1
<i>Marital Status</i>	3225	46.7	3	9.810	7.3	19.3	73.3
• Not Married	170	+ 53.5		*	6.0	17.9	76.2
• Married	2512	47.3			7.7	20.0	72.4
• Separated/Divorced	85	43.5			6.1	18.2	75.8
• Widowed	458	41.0			6.1	16.0	77.9
<i>Regular Source of Care</i>	3281	46.6	1	6.997	7.5	19.4	73.1
• Yes	2982	45.8		**	7.7	19.3	73.0
• No	299	+ 53.8			6.0	19.5	74.5

+ denotes most significant cause of difference within each variable

\* denotes significance of  $p < .05$ \*\* denotes significance of  $p < .01$ \*\*\* denotes significance of  $p < .001$

**Table 12: Significant Predictors of Physical Exam**

Variable	n	No Physical Exam (%)	df	Chi Square	Tried But Could Not Get The Service (%)	Did Not Try To Get The Service (%)	Did Not Need The Service (%) (Self Reported)
<i>Race/Ethnicity</i>	11358	38.5	3	22.313	13.5	23.6	62.9
• White	9581	38.1		***	12.9	23.5	63.5
• Black	989	37.0			18.7	24.1	57.1
• Hispanic	233	37.8			12.0	15.2	72.8
• Other	555	+ 47.9			14.0	25.9	60.1
<i>Age</i>	11227	38.5	5	17.574	13.6	23.5	62.9
• < 20	465	36.1		**	16.5	23.9	59.6
• 20 - 29	1147	+ 41.8			11.7	23.4	64.8
• 30 - 39	1511	40.9			13.1	22.7	64.2
• 40 - 49	1612	39.6			13.6	25.7	60.8
• 50 - 64	2633	38.2			13.6	26.0	60.4
• > 65	3859	36.5			14.1	21.1	64.8
<i>Beneficiary Group</i>	11559	38.5	3	22.283	13.5	23.6	62.9
• Active Duty (AD)	1618	38.6		***	12.1	19.9	68.0
• AD Family Member	1757	+ 42.7			12.7	24.9	62.4
• Retired (RET)	4505	38.8			15.0	24.0	61.0
• RET Family Member	3679	36.1			12.6	24.0	63.4
<i>Education Level</i>	11402	38.6	2	12.426	13.6	23.6	62.8
• < College Degree	6279	37.2		**	12.7	21.8	65.6
• College Degree	2429	+ 40.9			14.5	24.2	61.3
• > College Education	2694	39.9			14.7	27.0	58.3

+ denotes most significant cause of difference within each variable

\* denotes significance of  $p < .05$ \*\* denotes significance of  $p < .01$ \*\*\* denotes significance of  $p < .001$

Table 13: Significant Predictors of Prostate Examination

Variable	n	Lacking A Prostate Exam (%)	df	Chi Square	Tried But Could Not Get The Service (%)	Did Not Try To Get The Service (%)	Did Not Need The Service (%) (Self Reported)
<i>Race/Ethnicity</i>	3658	46.4	3	37.536	3.9	20.1	76.0
• White	3110	45.3		***	3.5	21.1	75.4
• Black	336	47.6			6.3	15.7	78.0
• Hispanic	73	39.7			3.6	21.4	75.0
• Other	139	+ 71.2			5.7	11.4	83.0
<i>Age</i>	3611	46.7	5	54.154	4.1	19.9	76.0
• < 20	110	49.1		***	8.3	14.6	77.1
• 20 - 29	333	+ 58.3			1.1	18.8	80.1
• 30 - 39	386	55.4			2.6	12.4	85.0
• 40 - 49	504	50.4			4.3	23.5	72.2
• 50 - 64	989	45.6			4.5	23.8	71.7
• > 65	1289	40.3			4.9	19.0	76.2
<i>Beneficiary Group</i>	3728	46.5	3	36.777	4.0	20.0	76.0
• Active Duty (AD)	853	54.5		***	3.1	14.6	82.3
• AD Family Member	85	48.2			2.7	16.2	81.1
• Retired (RET)	2717	43.6			4.6	22.5	72.9
• RET Family Member	73	+ 60.3			0.0	14.3	85.7
<i>Education Level</i>	3682	46.5	2	32.511	4.0	20.0	76.0
• < College Degree	1857	48.8		***	3.3	17.9	78.8
• College Degree	712	51.4			5.0	18.4	76.7
• > College Education	1113	+ 39.5			4.6	25.4	70.0
<i>Marital Status</i>	3673	46.5	3	11.430	4.0	20.1	75.9
• Not Married	301	54.5		**	1.3	18.2	80.5
• Married	2951	46.1			4.0	20.6	75.4
• Separated/Divorced	265	47.2			5.9	18.6	75.4
• Widowed	156	+ 39.1			7.0	17.5	75.4

+ denotes most significant cause of difference within each variable

\* denotes significance of  $p < .05$ \*\* denotes significance of  $p < .01$ \*\*\* denotes significance of  $p < .001$

**Table 14: Significant Predictors of Smoking Cessation Counseling**

Variable	n	No Smoking Cessation Counseling (%)	df	Chi Square	Tried But Could Not Get The Service (%)	Did Not Try To Get The Service (%)	Did Not Need The Service (%) (Self Reported)
<i>Gender</i>	11237	94.1	2	7.626	1.1	8.0	90.8
• Females	5384	94.7		*	1.0	8.0	91.0
• Males	5853	93.5			1.3	8.1	90.6
<i>Race/Ethnicity</i>	11096	94.2	6	12.856	1.1	8.0	90.8
• White	9364	94.4		*	1.1	8.0	90.9
• Black	953	+ 92.2			1.2	9.2	89.6
• Hispanic	231	94.8			1.0	7.2	91.9
• Other	548	93.8			1.2	7.3	91.5
<i>Beneficiary Group</i>	11273	94.1	6	16.255	1.1	8.0	90.8
• Active Duty (AD)	1582	94.1		*	0.9	9.3	89.8
• AD Family Member	1725	95.1			0.2	9.3	89.3
• Retired (RET)	4404	+ 93.2			0.5	7.5	91.2
• RET Family Member	3562	94.8			0.3	7.6	91.5
<i>Education Level</i>	11136	94.1	4	43.333	1.1	8.1	90.8
• < College Degree	6090	93.0		***	1.6	9.8	88.6
• College Degree	2384	94.8			1.0	7.8	91.3
• > College Education	2662	+ 96.1			0.3	4.7	95.0

+ denotes most significant cause of difference within each variable

\* denotes significance of  $p < .05$ \*\* denotes significance of  $p < .01$ \*\*\* denotes significance of  $p < .001$



Table 15: Significant Predictors of Wellness Screenings

Variable	n	No Wellness Screening (%)	df	Chi Square	Tried But Could Not Get The Service (%)	Did Not Try To Get The Service (%)	Did Not Need The Service (%) (Self Reported)
<i>Service Affiliation</i>	9359	54.3	3	9.348	5.6	15.3	79.1
• Army	2989	53.0		*	5.6	14.1	80.3
• Air Force	2906	54.0			5.7	15.0	79.3
• Navy/USMC	2870	54.9			5.5	17.3	77.2
• Other	594	+ 59.6			5.3	14.1	80.6
<i>Race/Ethnicity</i>	9833	54.3	3	10.538	5.7	15.2	79.1
• White	8326	53.9		*	5.2	14.8	79.9
• Black	850	53.9			8.6	18.5	72.9
• Hispanic	198	54.0			6.3	10.4	83.3
• Other	459	+ 61.7			8.7	16.4	74.9
<i>Age</i>	9714	54.5	5	25.448	5.6	15.2	79.1
• < 20	404	53.2		***	6.4	15.6	78.0
• 20 - 29	1005	+ 59.0			6.0	14.4	79.6
• 30 - 39	1331	56.1			4.5	13.2	82.3
• 40 - 49	1409	56.6			5.1	17.8	77.1
• 50 - 64	2276	54.8			5.8	16.2	78.0
• > 65	3289	51.4			6.0	14.4	79.6
<i>Beneficiary Group</i>	9995	54.3	3	17.803	5.7	15.2	79.2
• Active Duty (AD)	1405	56.2		***	5.4	13.8	80.8
• AD Family Member	1545	+ 58.3			5.3	13.5	81.1
• Retired (RET)	3893	53.9			6.0	17.2	76.7
• RET Family Member	3152	52.2			5.5	14.1	80.4
<i>Education Level</i>	9873	54.3	2	6.833	5.7	15.2	79.1
• < College Degree	5347	53.2		*	4.7	14.0	81.2
• College Degree	2150	+ 56.4			6.4	15.0	78.6
• > College Education	2376	54.9			7.1	17.8	75.0

+ denotes most significant cause of difference within each variable

\* denotes significance of  $p < .05$ \*\* denotes significance of  $p < .01$ \*\*\* denotes significance of  $p < .001$

## *Discussion*

This survey can be a valuable tool to help the decisionmakers within the MHSS understand patterns of use and access among its beneficiaries. Most of the aforementioned literature dealing with social characteristics and regular source of care focused their attention on the low income segment of society, identifying the major problem as being the individuals' ability to pay for their care. As would be expected, the results of this survey beat the civilian rates of regular source of healthcare. Jaen and others (1995) reported that about 23 percent of their respondents fell into the category of not having a regular source of care compared to DoD's 8.8 percent. The only other common variables studied was ethnicity. Jaen reported over 20 percent of their respondents in all ethnic categories, compared to less than 10 percent for DoD, lacked a regular source of care. Although the DoD survey did not address the respondents' reasons for not having or not using what would be considered a regular source of care, the ability to pay variable clearly would not impact this population as it would the rest of society. Of the four demographic variables considered by Jaen (age, gender, education, and ethnicity), all were significant predictors of source of care. The DoD survey determined four of the seven social characteristics are significant predictors for source of care. The only shared significant predictor between the two studies was age ( $p < .001$ ).

One potential problem that may have skewed some of the analysis was the wording of some of the questions dealing with preventive services. Several issues were identified with the wording of some of the questions. The questions are all covered by the main inquiry of: "Please indicate whether or not you received the following preventive services during the past 12 months." For example, military requirements dictate physical exams for active duty

members every five years (Table 12). The majority of the accepted battery of immunizations are given during childhood; this survey covered persons 18 years and older (Table 10). For smoking cessation counseling (Table 14), the respondent may have quit smoking several years ago, with or without the assistance of a healthcare provider. The principal issue arises around the response "It was not needed". This response could be interpreted several different ways, all of which have significantly different meanings. The instrument did not define if this response meant that a healthcare provider had advised the person that they did not need the service or if it was the respondent's personal determination as to whether they needed it or not. The data suggests the confusion surrounding this issue. About 40 percent of those responding that they had not gotten a dental exam said they did not need it (Table 8), 78 percent not receiving a blood pressure check stated they did not need one (Table 5), 72.5 percent answered they had not gotten their cholesterol checked because they didn't need it (Table 7), and 90 percent of the subjects responded that they did not need to get immunizations (Table 10).

The proposal for this project originally expected to find that persons who lacked a regular source of healthcare would provide a significant predictor for those who lacked the preventive services. This was not the case. Whether a respondent had a regular source of care or not was found not to be predictive of any of the preventive services questioned. This dispels the thought that the continuity of care provided by seeing the same primary care physician significantly impacts a patient's preventive/wellness service status.

The results of the gender-specific preventive service questions were alarming. Age was shown to be a significant indicator for whether a woman had received a mammogram. Even though the American Cancer Society (ACS) has determined that women between ages

40 and 49 should have mammography performed every one or two years, only 54.6 percent of the sample within this age group had received this early-detection measure within the last year. Of this number, 68.4 responded that they had not received this diagnostic measure because they did not need it. The ACS has also stated that women over the age of 50 should undergo mammography every year; in the DoD Beneficiary Survey, less than 60 percent had received a mammogram within this designated time frame, with over 71 percent of those not receiving the exam stating that they did not need it (See Table 11).

The National Cancer Institute has announced that all women should receive annual Pap smears when: (1) they become sexually active; or (2) upon reaching the age of 18. The results of that survey question showed that although only 32.3 percent reported they had not received a Pap smear, of those, 50 percent stated their reason was that they did not need the test. This despite the fact that all those surveyed were over 18 years old (See Table 6).

The recommended procedure for the detection of prostate cancer is the digital rectal exam, conducted on men over age forty on an annual basis. Of the sample surveyed in the age group over forty, 44 percent had not received their annual check. Of these, 56 percent responded that they did not need the procedure done (See Table 13).

#### *Meeting the Goals of Healthy People 2000*

As was previously mentioned, the Department of Health and Human Services has developed a list of health objectives for the United States. Several of the objectives overlap with the questions asked in the beneficiary survey (Table 22 at Appendix 3). How are DoD beneficiaries measuring up to these objectives? Due to the wording of the survey questions, it

is difficult to exactly match the objective up to the results of this survey. However, the following table depicts the level attained within the MHSS versus the objective of DHHS.

**Table 16: DoD Results versus HP2K Objectives**

Area of Concern	HP2K Objectives	DoD Level
Persons 35 and older using the oral healthcare system during the year	70%	62%
Adults having their blood pressure measured within two years and knowledge of whether pressure is high or low	90%	86% *
Adults having their cholesterol checked within five years	75%	61% **
Women aged 40 and older having received a mammogram	80%	58% **
Women age 50 and older having received a mammogram within one to two years	60%	59% **
Women age 18 and older having received a Pap test within one to three years	85%	68% **
Men age 50 and older having received a digital rectal exam within one year	40%	56%

\* The DoD survey specifies receiving the service "during the past 12 months" and does not ask if the subject knows if his or her blood pressure is high or low.

\*\* The DoD survey specifies receiving the service "during the past 12 months".

## CONCLUSIONS

### *General*

The 1995 Health Care Survey of DoD Beneficiaries provided the department with a good launching point from which to seriously analyze the MHSS. Although many of the users of the data generated by this survey are more seriously concerned with the patient satisfaction areas of the survey, much more can be learned from this survey. TRICARE should facilitate a resolution to the regular source of care challenges identified in this research. Although 91.8

percent of those surveyed did have what is considered a regular source of care, those who do not are causing an undue strain on an already overburdened system, resulting in higher costs of treatment, longer waiting times, and very little continuity of care.

The areas considered in this paper have shown that the MHSS faces a fairly great challenge of providing better education to its beneficiaries in the area of preventive services. Primary care physicians have normally been relied upon to provide this type of counseling to the population. As the MHSS embarks on its managed care endeavor, assigning beneficiaries to PCMs, it must be impressed upon these physicians that they are responsible for this education mission. However, individuals must take responsibility for keeping informed, pursuing the required or recommended services or treatments, and living a healthier lifestyle. DoD is placing a great deal of emphasis on the preventive medicine requirements in the award or renegotiation of the managed care support contracts for TRICARE.

The MHSS, in conjunction with commanders at all levels, retiree groups, and community organizations, must initiate an aggressive education program for its beneficiaries. For example, all beneficiaries should know whether their blood pressure and cholesterol levels are high, low, or normal, based on fairly recent readings. They should know at what point in their life and how often they need to get a Pap smear, mammogram, or rectal exam and what the results of these tests are.

Additionally, the population should be advised as to what they can do on their own to improve their condition or decrease their risk to certain medical problems. This, once again, is making individuals responsible for more of their own health.

### *Limitations*

There were several limitations which impacted on this research project. The data set used was the raw data set drawn directly from the returned surveys. This data had not undergone “backward data cleaning”. This process, based on the concept of implied continuation, assumes that if someone answers the second part of a contingent question and not the first part, the first response can be assumed based on the second response. This provides for more complete data with fewer blank responses. Additionally, this raw data had not been weighted. The final weighted and “cleaned” data set was not available in time to be reanalyzed. The data must be finalized in a more timely manner to facilitate its accurate, meaningful analysis.

The aforementioned wording of the survey questions is a significant limitation on the data received. One individual’s interpretation of “Did not need” a service could differ from a medical professional’s interpretation. Additionally, DoD’s ability to benchmark against the national standards set forth in *HP2K* are inhibited by the wording of the questions.

### *Recommendations for Future Research*

The key aspect that the 1995 Healthcare Survey did not address was the reason why some beneficiaries lack a regular source of care. Other researchers (Jaen and others 1995; Rask and others 1994; Baker, Steven and Brooks 1994; Grumbach and others 1993; Hayward and others 1991) used factors such as ability to pay, type of insurance, location, and convenience of hours, among others, to determine *why* patients either did not have a source of regular care or accessed the system at an inappropriate point. The 1996 version of the survey

does ask the recipients if inability to get an appointment was the reason they used the ED as their point of access into the MHSS, however this severely limits the identifiable reasons. The civilian sector has identified the biggest reason for patients accessing the system through the ED as their inability to pay for the care; since this is not an issue for the MHSS beneficiary, identifying the reasons would allow the leadership to focus on the real problems.

Another recommendation is that the questions in the survey be worded so that the results can be more easily compared to the *Healthy People 2000* objectives. This would provide a baseline as well as benchmarks of progress for comparison between the MHSS and the civilian healthcare system. The goal of the MHSS should be to surpass the standards set forth by *HP2K* since the MHSS does not face the major hurdle of the patients' ability to pay and, in general, has a more captive audience.

Analysis of future survey results should also focus on the "Regular Source of Care" and "Preventive Services" variables and their correlation with an individual's enrollment in TRICARE's Prime option. Prime, as previously mentioned, uses the tenets of managed care by assigning individuals PCMs and emphasizing the importance of preventive medicine. This type of analysis could serve as an indicator of how well TRICARE is working.

Future research should consider the combined effects of each of the variables, as well as their individual effects. This multivariate method of analysis, combined with using the final weighted data, could account for any differences between individuals.

These results should also prompt a much closer look at the beneficiaries' knowledge level with respect to preventive services. The beneficiaries should know what services they should receive, when in their life they should start receiving them, how often they should

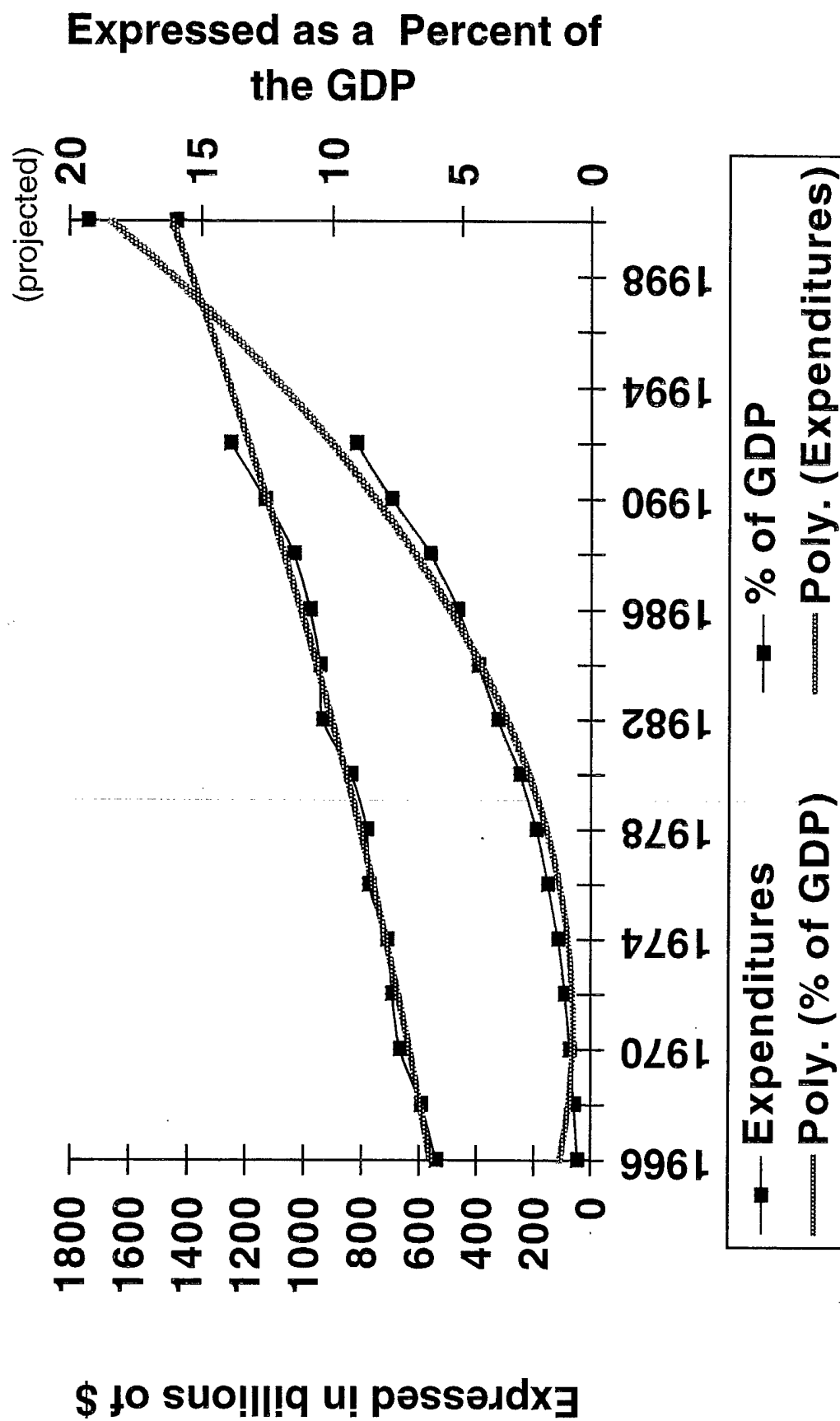


receive them, what the results are, and what those results mean. This could be another way of holding the patient more accountable for his or her own wellness.

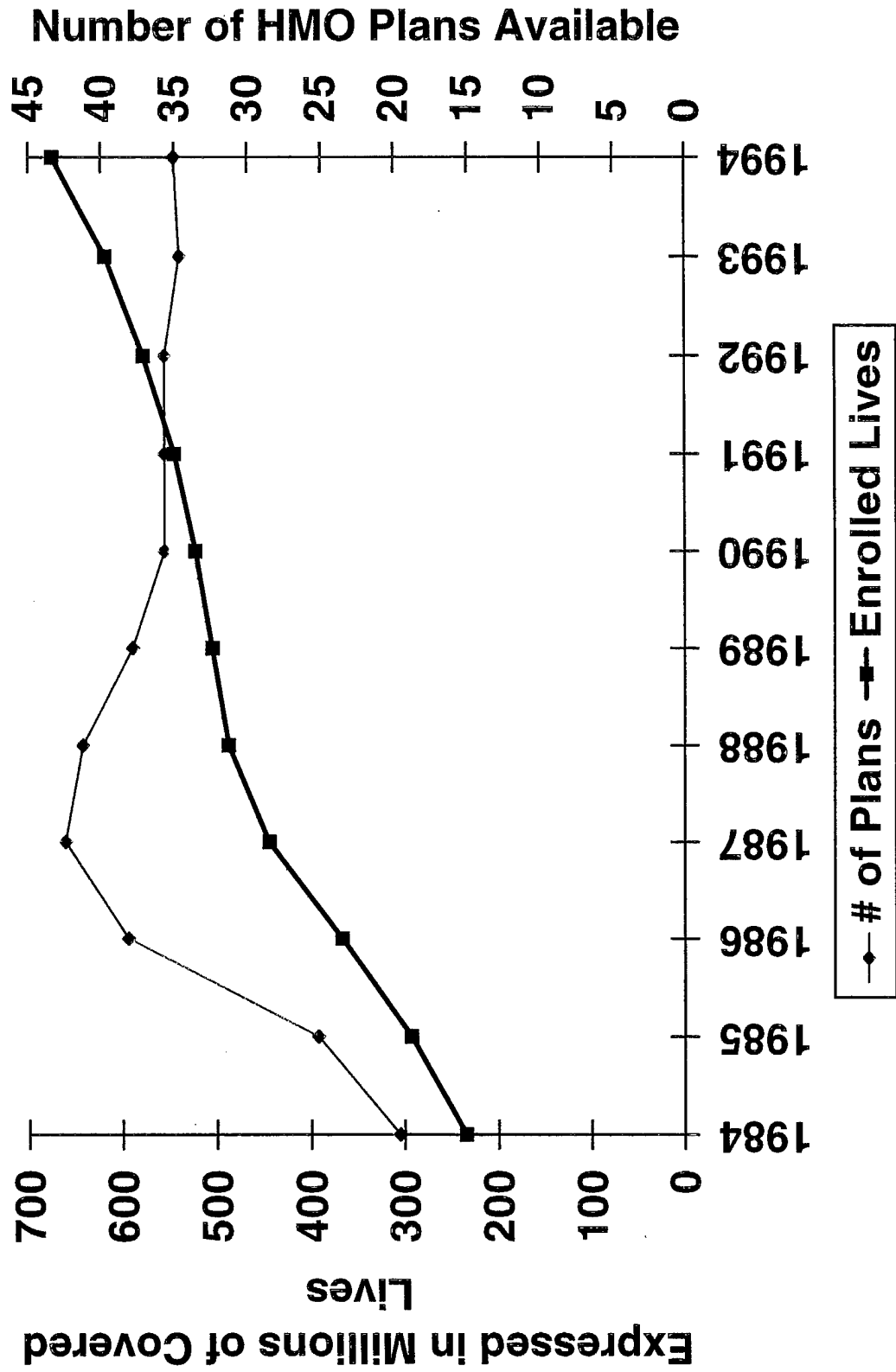
This project reemphasizes the importance of the physician-patient relationship. Of course, true emergencies must be taken to an emergency room but this should not be the site of routine care. Physicians at all points in the healthcare delivery system should be counseling patients on the best place to receive their routine medical care. Emphasis should be placed on the importance of continuity of care, the decreased cost of providing that care, the increased access to appropriate treatment, and the improved quality of the overall healthcare experience. Since not all persons access the system through a primary care provider, all healthcare providers must realize the importance of their responsibility for informing the population on the best ways to stay healthy, through healthier lifestyles and early detection procedures. Most importantly, however, is the fact that individuals must become more responsible for their own health and wellness.

## **Appendix 1 - Healthcare Statistics**

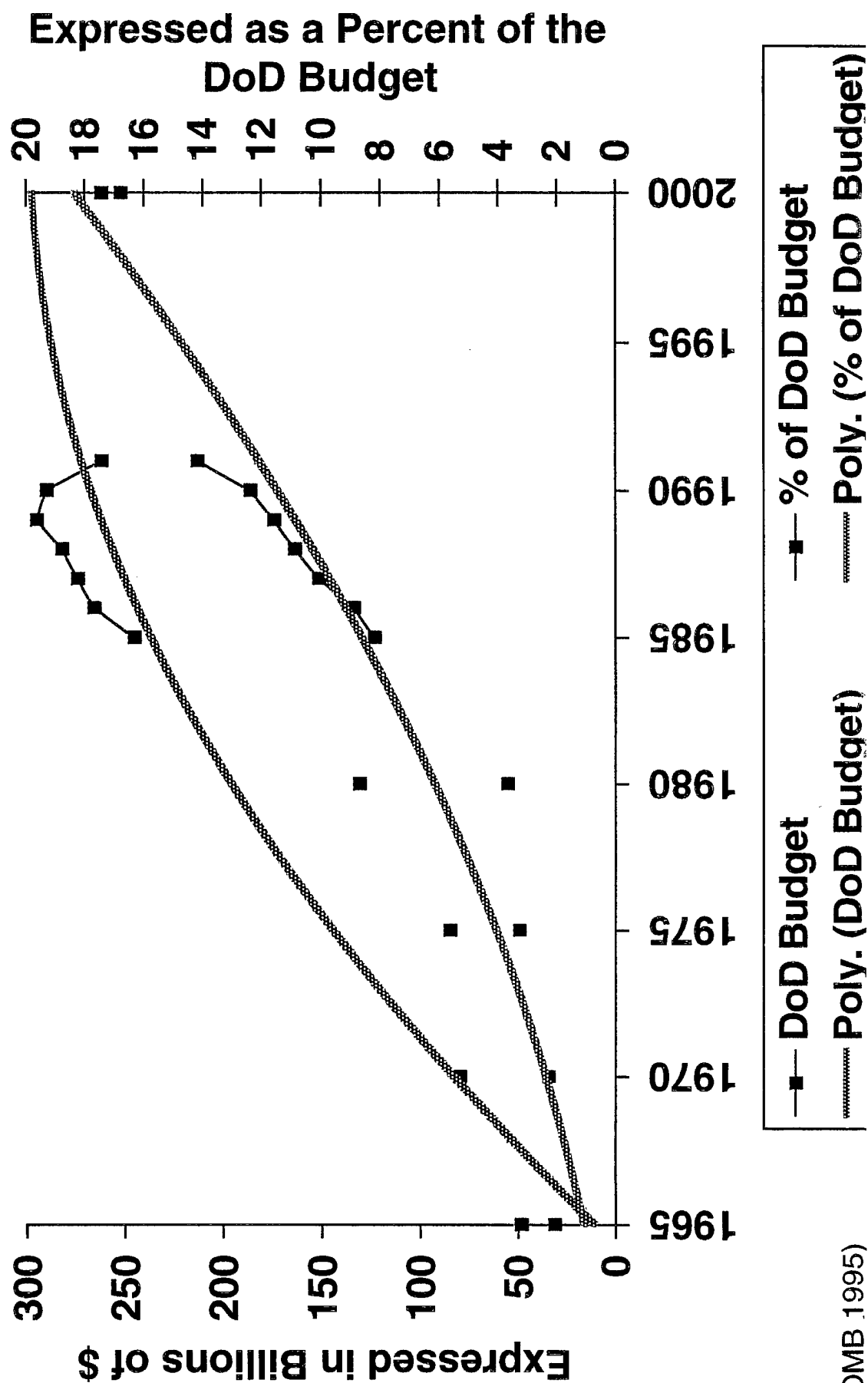
**Table 6:**  
**Expenditures for National Healthcare**



**Table 7:**  
**HMOs - Numbers and Enrollments**



**Table 8:**  
**DoD Expenditure on Healthcare**



## **Appendix 2 - TRICARE Triple Option Program**

**Table 20: TRICARE Uniform HMO Benefit ( Benefit, Fee and Copayment Schedule for FY 95)**

	<b>E4 &amp; Below ADFM</b>	<b>E5 &amp; Above ADFM</b>	<b>Retiree, Survivors, and Their Family Members</b>
<i>Annual Enrollment Fee</i>	\$0	\$0	\$230/Individual \$460/Family
<i>Outpatient Visits, Including Separate Radiology or Lab Services, and Home Health Visits</i>	\$6	\$12	\$12
<i>Emergency Room Visits</i>	\$10	\$30	\$30
<i>Mental Health Visits, Individual</i>	\$10	\$20	\$25
<i>Mental Health Visits, Group</i>	\$6	\$12	\$17
<i>Ambulatory Surgery</i>	\$25	\$25	\$25
<i>Prescriptions</i>	\$5	\$5	\$9
<i>Ambulance Services</i>	\$10	\$15	\$20
<i>Durable Medical Equipment, Prostheses, Supplies</i>	10%	15%	20%
<i>Inpatient Per Diem, General</i>	\$11, Minimum \$25/Admission	\$11, Minimum \$25/Admission	\$11, Minimum \$25/Admission
<i>Inpatient Per Diem, Mental Health and Substance Abuse</i>	\$20, Minimum \$25/Admission	\$20, Minimum \$25/Admission	\$20, Minimum \$25/Admission
<i>Catastrophic Cap on Out-of-Pocket Expenses Related to Allowable Charges</i>	\$1000	\$1000	\$3000

NOTE: This chart is for illustrative purposes only. It does not include all details of benefits and copayments.

**Table 21: TRICARE Triple Option Program (Benefit, Fee and Copayment Schedule for FY 95)**

	<b>TRICARE Standard</b>	<b>TRICARE Extra</b>	<b>TRICARE Prime</b>
<i>Enrollment Fee</i>	None	None	<u>AD &amp; ADFM</u> - None <u>Others</u> - \$230/Individual \$460/Family
<i>Outpatient Deductible</i>	\$300/Family \$100 E4 & below	\$150/Individual \$300/Family	None
<i>Outpatient Services Cost Share, Including Mental Health, Emergency Services, Etc.</i>	<u>ADFM</u> - 20% After Deductible Met <u>Others</u> - 25% After Deductible Met	<u>ADFM</u> - 15% After Deductible Met <u>Others</u> - 20% After Deductible Met	See Table 9- Schedule of Uniform HMO Benefit Copayments
<i>Inpatient Services Cost Share, Including Maternity and Skilled Nursing Facilities; NOT Including Mental Health</i>	<u>ADFM</u> - the Greater of \$25/admission <u>or</u> Current Per Diem <u>Others</u> - Lesser of Applicable Per Diem (\$323 in FY 95) <u>or</u> 25% of Both Institutional Billed Charges and Professional Charges	<u>ADFM</u> - the Greater of Applicable Per Diem (\$9.30 in FY94) <u>or</u> \$25 Total <u>Others</u> - Lesser of \$250/Day <u>or</u> 25% of Institutional Billed Charges plus 20% of Professional Charges	See Table 9- Schedule of Uniform HMO Benefit Copayments
<i>Ambulatory Surgery</i>	<u>ADFM</u> - \$25/Episode <u>Others</u> - 25% of Allowable Charges After Deductible Met	<u>ADFM</u> - \$25/Episode <u>Others</u> - 20% of Allowable Charges, No Deductible	See Table 9- Schedule of Uniform HMO Benefit Copayments
<i>Prescription Drug Benefits</i>	<u>ADFM</u> - 20% Copay After Deductible Met <u>Others</u> - 25% Copay After Deductible Met	<u>ADFM</u> - 15% Copay, No Deductible <u>Others</u> - 20% Copay, No Deductible	<u>AD &amp; ADFM</u> - \$5/Prescription <u>Others</u> - \$9/Prescription
<i>Mail Order Pharmacy</i>	<u>ADFM</u> - \$4/Prescription <u>Others</u> - \$8/Prescription	<u>ADFM</u> - \$4/Prescription <u>Others</u> - \$8/Prescription	<u>AD &amp; ADFM</u> - \$4/Prescription <u>Others</u> - \$8/Prescription
<i>Hospitalization for Mental Illness and Substance Abuse</i>	<u>ADFM</u> - the Greater of \$25/Admission <u>or</u> \$20/Day <u>Others</u> - the Lesser of Applicable Per Diem (\$132 in FY 95) <u>or</u> 25% of Both Institutional Billed Charges and Professional Charges	<u>ADFM</u> - the Greater of \$25/Admission <u>or</u> \$20/Day <u>Others</u> - 20% of Both Institutional Billed Charges and Professional Charges	<u>ADFM</u> - the Greater of \$25/Admission <u>or</u> \$20/Day <u>Others</u> - \$40/Day

NOTE: This chart is for illustrative purposes only. It does not include all details of benefits and copayments.



**Appendix 3 - *Healthy People 2000* Overlapping Objectives**

**Table 22: Healthy People 2000 Overlapping Objectives**

Objective	Healthy People 2000 Objective
3.16	Increase to at least 75 percent the proportion of primary care and oral healthcare providers who routinely advise cessation and provide assistance and follow-up for all of their tobacco-using patients.
13.12	Increase to at least 90 percent the proportion of all children entering school programs for the first time who have received an oral health screening, referral, and follow-up for necessary diagnostic, preventive, and treatment services.
13.14	Increase to at least 70 percent the proportion of people aged 35 and older using the oral healthcare system during each year.
15.10	Reduce overweight to a prevalence of no more than 20 percent among people aged 20 and older and no more than 15 percent among adolescents aged 12 through 19.
15.12	Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 20 and older (20 percent for military personnel).
15.13	Increase to at least 90 percent the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high.
15.14	Increase to at least 75 percent the proportion of adults who have had their blood cholesterol checked within the preceding 5 years.
16.10	Increase to at least 75 percent the proportion of primary care providers who routinely counsel patients about tobacco use cessation, diet modification, and cancer screening recommendations.
16.11	Increase to at least 80 percent the proportion of women aged 40 and older who have ever received a clinical breast examination and a mammogram, and to at least 60 percent those aged 50 and older who have received them within the preceding 1 to 2 years.
16.12	Increase to at least 95 percent the proportion of women aged 18 and older with uterine cervix who have ever received a Pap test, and to at least 85 percent those who have received a Pap test within the preceding 1 to 3 years.

(Table 10 continued)

16.14	Increase to at least 40 percent the proportion of people aged 50 and older visiting a primary care provider in the preceding year who have received oral, skin, and digital rectal examinations during one such visit.
20.11	<p>Increase immunization levels as follows:</p> <ul style="list-style-type: none"> <li>• Basic immunization series among children under age 2 - at least 90 percent</li> <li>• Basic immunization series among children in licensed child care facilities and kindergarten through post-secondary education institutions - at least 95 percent</li> <li>• Pneumococcal pneumonia and influenza immunization among institutionalized chronically ill and older people - at least 80 percent</li> <li>• Pneumococcal pneumonia and influenza immunization among non-institutionalized, high-risk populations, as defined by the Immunization Practices Advisory Committee - at least 60 percent</li> <li>• Hepatitis B immunization among high-risk populations, including infants of surface antigen-positive mothers to at least 90 percent; occupationally exposed workers to at least 90 percent</li> </ul>
20.14	Increase to at least 90 percent the proportion of primary care providers who provide information and counseling about immunizations and offer immunizations as appropriate for their patients.

(DHHS 1990)

**Appendix 4 - 1994-1995 Health Care Survey of DoD Beneficiaries**

# 1994-95 Health Care Survey of DoD Beneficiaries



DMDC Survey No. 94-004

DEFENSE MANPOWER DATA CENTER  
SURVEY PROCESSING ACTIVITY  
c/o DATA RECOGNITION CORPORATION  
5900 BAKER ROAD  
MINNETONKA, MN 55345-5967

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Approved  
 OMB No.: 0704-0362  
 Expires: 03/31/97  
 RCS: DD-HA(A) 1942  
 Expires: 04/15/97

## PLEASE NOTE:

### Agency Disclosure Notice

Public reporting for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302; and to the Office of Management and Budget, Paperwork Reduction Project (0704-0362), Washington, DC 20503. PLEASE DO NOT RETURN YOUR QUESTIONNAIRE TO EITHER OF THESE ADDRESSES. SEND YOUR COMPLETED QUESTIONNAIRE TO THE ADDRESS SHOWN ON THE FRONT OF THIS BOOKLET.

### Privacy Notice

According to the Privacy Act of 1974 (Public Law 93-573), the Department of Defense is required to inform you of the purposes and use of this survey. Please read it carefully.

Authority: The Federal Government may collect the information requested in the 1994 Health Care Survey of DoD Beneficiaries under the authority of Public Law 102-484 (10 USC 1071 note), Section 724 of the FY 1993 Defense Authorization Act.

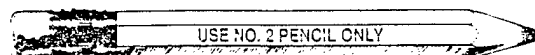
Principal Purpose: This survey is being conducted to help policy makers learn more about the military health care system. Information from the survey will be used to assist in the formulation of policies that may be needed to improve the military health care system. In addition, the survey information will be used by military medical treatment facility commanders to evaluate the services provided. This survey will be conducted on an annual basis.

Disclosure: Providing information in this questionnaire is voluntary. There is no penalty if you choose not to respond. However, maximum participation is essential to ensure that the data are complete and representative. Your survey questionnaire will be treated as confidential. Any identifiable information will be used only by persons involved in the survey. Only group statistics will be reported in findings from this project.

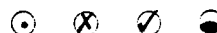
Routine Uses: An annual report to Congress will be prepared using the survey data. Other reports will be provided to the Office of the Assistant Secretary of Defense (Health Affairs), each military service and to military medical treatment facility commanders. Some findings may be reported in manuscripts presented at conferences, symposia, scientific meetings, and professional journals.

### MARKING INSTRUCTIONS

- Make heavy black marks that fill the response circles.
- Do not make any marks outside of the response circles.
- If you change your mind, erase completely.



#### WRONG MARKS



#### RIGHT MARK



# ABOUT THIS QUESTIONNAIRE

## WHY ME?

You have been selected at random to be a part of the group of people which represent all people entitled to use the military health care system. There are over 8 million people who are entitled to use the military health care system. Enough people were selected to participate in this survey so that valid conclusions can be made about the military health services system.

## WHY SHOULD I BOTHER? DO SURVEYS CHANGE ANYTHING?

In general, statistics from surveys provide valuable information to policy makers and planners about particular programs. Survey data helps identify the parts of our health care system that work well and the parts of our system that need to be improved. Changes to the system may take time, but filling out this survey will help make sure we make the right changes as quickly as possible. **Your response counts.**

## WILL MY SURVEY RESULTS BE KEPT PRIVATE?

Yes. Under no circumstances will any information about identifiable individuals be released to anyone. Any identifiable information will be used only by persons engaged in, and for the purposes of, the survey. Your information will be combined with the information from many other people to report how groups of people view the health care they receive.

## AREN'T SOME OF THE QUESTIONS VERY PERSONAL?

Yes. Although people will have different views on what is or is not personal, most people will consider at least some of the questions to be very personal. We are asking these questions to evaluate the military health care system. Good estimates can be made only if most people answer all the questions in the survey. However, you can choose not to answer particular items. **Please do not discard the entire survey because there are some particular items that you want to skip.**

## WHOSE HEALTH CARE DO WE WANT TO KNOW ABOUT?

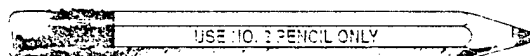
We want to know about the health care you received during the past 12 months. Unless the instructions tell you otherwise, answer each question for the health care you received as an individual during the past 12 months.

## WHAT IS A HEALTH CARE PROVIDER?

A health care provider is someone you receive health care from. This individual may be a doctor or a medical doctor who is a specialist. A health care provider can also be a physician's assistant, psychologist, nurse, nurse practitioner, dentist, optometrist, physical therapist, pharmacist, chiropractor, podiatrist, etc.

## WHAT IS A MILITARY MEDICAL TREATMENT FACILITY?

This is where you may receive health care, usually given by a health care provider at a military facility. This may include a military hospital, clinic, doctor's office, infirmary, or sick call.



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**SECTION I: YOUR USE OF MEDICAL SERVICES**

1. Which of the following places do you **USUALLY** go to when sick or when advice is needed about your health? **DO NOT** include places you go for dental care. **MARK ONLY THE ONE BEST ANSWER.**

- ☐ Military hospital, clinic, or dispensary (including sick call)  
☐ Military hospital emergency room  
☐ PRIMUS or NAVCARE clinic  
☐ Veterans Administration (VA) hospital outpatient clinic  
☐ Civilian doctor's office  
☐ Civilian hospital or clinic  
☐ Civilian hospital emergency room  
☐ Another type of military place (specify) →  
☐ Another type of civilian place (specify) →  
☐ I do not have a usual source of care  
☐ Don't know what kind of place

2. Are you now covered by any of the following health insurance programs? **MARK ALL THAT APPLY.**

- ☐ Does not apply; I am not covered by any health insurance program  
☐ CHAMPUS  
☐ Medicare, Part B  
☐ Supplemental insurance (Medical insurance you usually get through military or retiree associations. It helps pay the amount due after CHAMPUS or MEDICARE pays its share of charges for medical care.)  
☐ Private health insurance (Blue Cross/Blue Shield, Prudential, AARP, etc. or a prepaid health plan or HMO (Health Maintenance Organization)  
☐ Other (specify) →  
☐ Don't know

3. If you are covered by private health insurance or by a prepaid health plan or HMO (Health Maintenance Organization), who pays for this insurance?

- ☐ Does not apply; do not have this type of plan  
☐ Cost paid entirely by myself or my family  
☐ Cost shared by my family and current or former employers  
☐ Cost paid entirely by current or former employers  
☐ Other (specify) →

4. Please indicate whether or not you received the following preventive services during the **past 12 months**. If you did not receive the service, please indicate why not.

## a. General physical exam

- ☐ Yes  
☐ No → ☐ It was not needed  
☐ It was needed but I did not try to get it  
☐ I tried but could not get the service  
☐ Not sure

## b. Blood pressure check

- ☐ Yes  
☐ No → ☐ It was not needed  
☐ It was needed but I did not try to get it  
☐ I tried but could not get the service  
☐ Not sure

## c. Cholesterol screening

- ☐ Yes  
☐ No → ☐ It was not needed  
☐ It was needed but I did not try to get it  
☐ I tried but could not get the service  
☐ Not sure

## d. Wellness screening

- ☐ Yes  
☐ No → ☐ It was not needed  
☐ It was needed but I did not try to get it  
☐ I tried but could not get the service  
☐ Not sure

## e. Immunizations

- ☐ Yes  
☐ No → ☐ It was not needed  
☐ It was needed but I did not try to get it  
☐ I tried but could not get the service  
☐ Not sure

## f. Dental exam

- ☐ Yes  
☐ No → ☐ It was not needed  
☐ It was needed but I did not try to get it  
☐ I tried but could not get the service  
☐ Not sure

## g. Smoking cessation

- ☐ Yes  
☐ No → ☐ It was not needed  
☐ It was needed but I did not try to get it  
☐ I tried but could not get the service  
☐ Not sure

## h. Weight control

- ☐ Yes  
☐ No → ☐ It was not needed  
☐ It was needed but I did not try to get it  
☐ I tried but could not get the service  
☐ Not sure



4. continued . . .

**i. Pap smear**

- ☐ Not applicable (I am male)  
☐ Yes  
☐ No → ☐ It was not needed  
                  ☐ It was needed but I did not try to get it  
                  ☐ I tried but could not get the service  
☐ Not sure

**j. Mammography**

- ☐ Not applicable (I am male)  
☐ Yes  
☐ No → ☐ It was not needed  
                  ☐ It was needed but I did not try to get it  
                  ☐ I tried but could not get the service  
☐ Not sure

**k. Prostate exam**

- ☐ Not applicable (I am female)  
☐ Yes  
☐ No → ☐ It was not needed  
                  ☐ It was needed but I did not try to get it  
                  ☐ I tried but could not get the service  
☐ Not sure

**5. Have you been to any hospital, clinic, pharmacy, doctor's office, or sick call for YOUR OWN HEALTH, during the past 12 months?**

- ☐ Yes  
☐ No → **GO TO QUESTION 61a  
ON PAGE 13.**

**6a. Did you receive most of your medical care from a military medical treatment facility (MMTF) during the past 12 months?**

- ☐ Yes → **GO TO QUESTION 7.**  
☐ No

**6b. What reason (or reasons) explain why you did not receive most of your medical care from a military medical treatment facility (MMTF) during the past 12 months?**

**MARK ALL THAT APPLY.**

- ☐ I have never tried to use the MMTF  
☐ The MMTF lacks the services I need  
☐ The MMTF is not located in a good place  
☐ MMTF personnel have been rude to me  
☐ MMTF providers are not very thorough in their examinations  
☐ I do not get to see the same provider each time I go to the MMTF  
☐ MMTF care is not as good as civilian care  
☐ My schedule conflicts with the times that the MMTF offers care  
☐ I live too far from the MMTF  
☐ It's too hard to get an appointment at the MMTF  
☐ I wait too long to see a provider at the MMTF  
☐ I was referred or sent by the MMTF to a civilian facility  
☐ I simply prefer another source of care  
☐ Some other reason (specify) →



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7. Please indicate how many times you went to a doctor's office or outpatient clinic for your own health care during the past 12 months? MARK ONE RESPONSE IN EACH ROW.

	No visits	1	2	3	4	5	6	7	8	9	10	11 or more
a. Illness or injury .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Follow up for injury or illness .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. General physical exam .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Prescription refill only .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Eye exam only .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Prenatal care .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Same day surgery .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Mental health .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Substance abuse .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Other type of care .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

(If you marked 1 or more for other type of care, please specify type of care.) →

8. During the past 12 months, how many times did you visit a health care provider at any of the following places for your own health care? DO NOT count doctors seen while an overnight patient in a hospital, dental care, or visits to pick up prescriptions. Your best guess will do.

	No visits	1	2	3	4	5	6	7	8	9	10	11 or more
a. Military or field/fleet hospital or clinic (not including sick call) .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Sick call visits to a military hospital or clinic (If you are not an active duty member, mark NA.) .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Civilian doctor's office, hospital, or clinic ....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. PRIMUS or NAVCARE clinic .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Veterans Administration (VA) hospital or clinic .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Another type of place .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

(If you marked 1 or more for another type of place, please specify type of place.) →

9. During the past 12 months, how many nights did you personally stay OVERNIGHT as a patient in a military or civilian hospital? Your best guess will do.

	No nights	1	2	3	4	5	6	7	8	9	10	11 or more
a. Military or field/fleet hospital .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Civilian hospital .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Veterans Administration (VA) hospital .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Another type of place .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

(If you marked 1 or more for another type of place, please specify type of place.) →

10. What type of medical facility did you use for your **MOST RECENT** doctor's office/outpatient visit? **MARK ONE.**

- ☐ Military hospital emergency room
- ☐ Military or field/fleet hospital, clinic, or dispensary (including sick call)
- ☐ Civilian hospital emergency room
- ☐ Civilian doctor's office, hospital, or clinic
- ☐ PRIMUS or NAVCARE Clinic
- ☐ Veterans Administration (VA) hospital or clinic
- ☐ Another type of military place (specify) →

☐ Another type of civilian place (specify) →

☐ I had no visits in the past 12 months

11. Thinking about your own health care during the past 12 months, how many telephone calls did you or a family member **USUALLY** make to get an appointment for you?

**For civilian providers? MARK ONE.**

- ☐ I had no visits to civilian providers
- ☐ None; someone at the facility arranged these appointments
- ☐ 1-2
- ☐ 3-5
- ☐ 6-9
- ☐ 10 or more
- ☐ Facility does not schedule appointments by telephone

**For military providers? MARK ONE.**

- ☐ I had no visits to military providers
- ☐ None; someone at the facility arranged these appointments
- ☐ 1-2
- ☐ 3-5
- ☐ 6-9
- ☐ 10 or more
- ☐ Facility does not schedule appointments by telephone

12. Thinking about your own health care during the past 12 months, how long did you **USUALLY** wait between the time you scheduled an appointment and the day you actually saw the provider? (Exclude follow-on visits scheduled by the provider.)

**For civilian providers? MARK ONE.**

- ☐ I had no visits to civilian providers
- ☐ Less than 3 days
- ☐ 3 days to less than 1 week
- ☐ 1 week to less than 2 weeks
- ☐ 2 weeks to less than 4 weeks
- ☐ 4 weeks to less than 6 weeks
- ☐ 6 weeks to less than 8 weeks
- ☐ More than 8 weeks

**For military providers? MARK ONE.**

- ☐ I had no visits to military providers
- ☐ Less than 3 days
- ☐ 3 days to less than 1 week
- ☐ 1 week to less than 2 weeks
- ☐ 2 weeks to less than 4 weeks
- ☐ 4 weeks to less than 6 weeks
- ☐ 6 weeks to less than 8 weeks
- ☐ More than 8 weeks

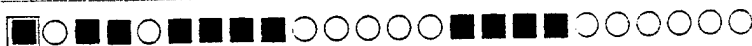
13. Again, thinking about your own health care during the past 12 months, how long did you **USUALLY** wait in the office or clinic to see the health care provider?

**For civilian providers? MARK ONE.**

- ☐ I had no visits to civilian providers
- ☐ Less than 10 minutes
- ☐ 11 to 15 minutes
- ☐ 16 to 30 minutes
- ☐ 31 to 45 minutes
- ☐ 46 minutes to 1 hour
- ☐ More than 1 hour, but less than 2 hours
- ☐ 2 hours or more

**For military providers? MARK ONE.**

- ☐ I had no visits to military providers
- ☐ Less than 10 minutes
- ☐ 11 to 15 minutes
- ☐ 16 to 30 minutes
- ☐ 31 to 45 minutes
- ☐ 46 minutes to 1 hour
- ☐ More than 1 hour, but less than 2 hours
- ☐ 2 hours or more



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14. Again, thinking about your own health care during the past 12 months, how long did you USUALLY travel to the place where you received care?

**For civilian providers? MARK ONE.**

- ☐ I had no visits to civilian providers
- ☐ Less than 10 minutes
- ☐ 11 to 15 minutes
- ☐ 16 to 30 minutes
- ☐ 31 to 45 minutes
- ☐ 46 minutes to 1 hour
- ☐ More than 1 hour, but less than 2 hours
- ☐ 2 hours or more

**For military providers? MARK ONE.**

- ☐ I had no visits to military providers
- ☐ Less than 10 minutes
- ☐ 11 to 15 minutes
- ☐ 16 to 30 minutes
- ☐ 31 to 45 minutes
- ☐ 46 minutes to 1 hour
- ☐ More than 1 hour, but less than 2 hours
- ☐ 2 hours or more

15. When you went for health care during the past 12 months, how often did you see the same provider?

**For civilian providers? MARK ONE.**

- ☐ I do not use civilian providers
- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Sometimes
- ☐ Rarely or never

**For military providers? MARK ONE.**

- ☐ I do not use military providers
- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Sometimes
- ☐ Rarely or never

16. When you want to see a specialist about your own health, do you first have to get an approval/referral?

- ☐ Yes
- ☐ No
- ☐ Don't know

## SECTION II: SATISFACTION WITH YOUR HEALTH CARE

This section asks about how you feel about the health care you received during the **PAST 12 MONTHS**. Your responses should be based only on the health care you as an individual received. (Later, this survey will have questions on your children's care.)

17. Please mark the one statement that best describes your use of civilian and military health care services during the past 12 months and follow the instructions. Your answer to this question will decide how you answer questions 18 to 60. **MARK ONLY THE ONE BEST ANSWER AND THEN FOLLOW THE INSTRUCTIONS.**

☐ I have used only health care or services provided by military medical treatment facilities (MMTF), PRIMUS, or NAVCARE (ANSWER QUESTIONS 18-60 IN COLUMN B ONLY)

☐ I have used health care or services provided both by CHAMPUS, private insurance, Medicare, VA, or other sources and by military medical treatment facilities, PRIMUS or NAVCARE (ANSWER QUESTIONS 18-60 IN BOTH COLUMNS A AND B)

☐ I have used only health care or services provided by CHAMPUS, private insurance, Medicare, VA, or other sources (ANSWER QUESTIONS 18-60 IN COLUMN A ONLY)

Column A  
CHAMPUS, Private,  
Medicare, VA, Other

Column B  
Military Medical Treatment  
Facility, PRIMUS, NAVCARE

Please indicate how much you agree or disagree with the following.

Strongly Disagree  
Disagree  
Neither Agree nor Disagree  
Agree  
Strongly Agree

Strongly Disagree  
Disagree  
Neither Agree nor Disagree  
Agree  
Strongly Agree

18. I am satisfied with the health care I receive .....

SA A N D SD

..... SA A N D SD

19. I would recommend this type of health care to my family or friends who needed care .....

SA A N D SD

..... SA A N D SD



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Column A  
CHAMPUS, Private,  
Medicare, VA, Other

Column B  
Military Medical Treatment  
Facility, PRIMUS, NAVCARE

Please rate the following aspects  
of your health care. (If a question  
does not apply to you, please mark  
Not Applicable.)

	Column A CHAMPUS, Private, Medicare, VA, Other						Column B Military Medical Treatment Facility, PRIMUS, NAVCARE					
	Not Applicable						Not Applicable					
	Poor						Poor					
	Fair						Fair					
	Good						Good					
	Very Good						Very Good					
	Excellent						Excellent					
20. Convenience of location of treatment .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
21. Convenience of hours .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
22. Access to health care whenever you need it .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
23. Access to a specialist if you need one .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
24. Access to inpatient hospital care if you need it .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
25. Access to medical care in an emergency .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
26. Ease of making appointments for health care by phone ....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
27. Length of time you wait at office to see the health care provider .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
28. Length of time you wait between making an appointment for routine care and the day of your visit .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
29. Availability of health care information or advice by phone .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
30. Services available for getting prescriptions filled .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
31. Thoroughness of examination .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
32. Ability to diagnose my health care problems .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
33. Skill of health care providers .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA

Column A  
CHAMPUS, Private,  
Medicare, VA, Other

Column B  
Military Medical Treatment Facility,  
PRIMUS, NAVCARE

Please rate the following aspects of your health care. (If a question does not apply to you, please mark Not Applicable.)

	Not Applicable						Not Applicable					
	Poor						Poor					
	Fair						Fair					
	Good						Good					
	Very Good						Very Good					
	Excellent						Excellent					
34. Thoroughness of treatment .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
35. The outcomes of your health care (how much you are helped) .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
36. Overall quality of health care .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
37. Provider's explanation of health care procedures .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
38. Provider's explanation of medical tests .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
39. Attention provider gives to what you have to say .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
40. Advice provider gives you about ways to avoid illness and stay healthy .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
41. Courtesy shown to you by administrative staff (e.g., receptionists) .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
42. Courtesy shown to you by health care providers .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
43. Provider's concern for you as a person .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
44. Provider's concern for your privacy .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
45. Reassurance and support offered to you by health care providers .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
46. Amount of time with health care providers during a visit .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
47. Ability to choose health care providers .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
48. Ease of seeing the health care provider of your choice .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
49. Health care providers' personal interest in the outcome of your problem .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
50. Protection you have against hardship due to medical expenses .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
51. Help with arrangements to get the health care you need without financial problems .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA



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Column A  
CHAMPUS, Private,  
Medicare, VA, Other

Column B  
Military Medical Treatment Facility,  
PRIMUS, NAVCARE

Thinking about your own health care  
during the past 12 months, how would  
you rate the following OUTPATIENT  
SERVICES? (If you did not use a specific  
service, please mark Not Applicable.)

	Column A CHAMPUS, Private, Medicare, VA, Other						Column B Military Medical Treatment Facility, PRIMUS, NAVCARE					
	Not Applicable						Not Applicable					
	Poor						Poor					
	Fair						Fair					
	Good						Good					
	Very Good						Very Good					
	Excellent						Excellent					
52. Family practice/primary care .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
53. Emergency Room .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
54. OB/GYN .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
55. Surgery .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
56. Optometry .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
57. Mental Health .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
58. Physical Therapy .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
59. Laboratory .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA
60. Pharmacy .....	E	VG	G	F	P	NA	E	VG	G	F	P	NA



61a. Please indicate how many times you went to a dental office or clinic for your own dental care during the past 12 months.

- ☐ No visits → **GO TO QUESTION 62.**  
☐ 1 visit  
☐ 2 visits  
☐ 3 visits  
☐ 4 visits  
☐ 5 visits  
☐ 6 visits  
☐ 7 visits  
☐ 8 visits  
☐ 9 visits  
☐ 10 visits  
☐ 11 or more visits

61b. In thinking about your own dental care during the past 12 months, how would you rate the dental care provided by Military Dental Treatment Facilities? **MARK ONE.**

- ☐ Excellent  
☐ Very good  
☐ Good  
☐ Fair  
☐ Poor  
☐ Not applicable; I have not received dental care from a military dental treatment facility

61c. In thinking about your own dental care during the past 12 months, how would you rate the dental care provided by Delta Dental, private insurance, or other sources? **MARK ONE.**

- ☐ Excellent  
☐ Very good  
☐ Good  
☐ Fair  
☐ Poor  
☐ Not applicable; I have not received dental care provided by Delta Dental, private insurance, or other sources during the past 12 months

### SECTION III: CARE FOR YOUR ELIGIBLE CHILDREN

Eligible children are UNMARRIED children, including adopted children or stepchildren, who are legally dependent on you for over half their support AND:

- Are not yet 21 years old; OR
- Attend college and are not yet 23 years old; OR
- Are of any age and have a mental or physical handicap

62. As defined above, how many eligible children do you have?

- ☐ None → **GO TO QUESTION 68.**  
☐ One  
☐ Two  
☐ Three  
☐ Four  
☐ Five  
☐ Six or more

63. How many of your eligible children are now living with you?

- ☐ None → **GO TO QUESTION 68.**  
☐ One  
☐ Two  
☐ Three  
☐ Four  
☐ Five  
☐ Six or more

64. Thinking about your children's health care during the past 12 months, how many telephone calls did you or a family member USUALLY make to get an appointment?

For civilian providers? MARK ONE.

- ☐ My child (children) had no visits to civilian providers
- ☐ None; someone at the facility arranged these appointments
- ☐ 1-2
- ☐ 3-5
- ☐ 6-9
- ☐ 10 or more
- ☐ Facility does not schedule appointments by telephone

For military providers? MARK ONE.

- ☐ My child (children) had no visits to military providers
- ☐ None; someone at the facility arranged these appointments
- ☐ 1-2
- ☐ 3-5
- ☐ 6-9
- ☐ 10 or more
- ☐ Facility does not schedule appointments by telephone

65. Thinking about your children's health care during the past 12 months, how long did you USUALLY wait between the time you scheduled an appointment for care and the day your children actually saw the provider?

For civilian providers? MARK ONE.

- ☐ My child (children) had no visits to civilian providers
- ☐ Less than 3 days
- ☐ 3 days to less than 1 week
- ☐ 1 week to less than 2 weeks
- ☐ 2 weeks to less than 4 weeks
- ☐ 4 weeks to less than 6 weeks
- ☐ 6 weeks to less than 8 weeks
- ☐ More than 8 weeks

For military providers? MARK ONE.

- ☐ My child (children) had no visits to military providers
- ☐ Less than 3 days
- ☐ 3 days to less than 1 week
- ☐ 1 week to less than 2 weeks
- ☐ 2 weeks to less than 4 weeks
- ☐ 4 weeks to less than 6 weeks
- ☐ 6 weeks to less than 8 weeks
- ☐ More than 8 weeks

66. Again, thinking about your children's health care during the past 12 months, how long did you USUALLY wait in the office or clinic to see the health care provider?

For civilian providers? MARK ONE.

- ☐ My child (children) had no visits to civilian providers
- ☐ Less than 10 minutes
- ☐ 11 to 15 minutes
- ☐ 16 to 30 minutes
- ☐ 31 to 45 minutes
- ☐ 46 minutes to 1 hour
- ☐ More than 1 hour, but less than 2 hours
- ☐ 2 hours or more

For military providers? MARK ONE.

- ☐ My child (children) had no visits to military providers
- ☐ Less than 10 minutes
- ☐ 11 to 15 minutes
- ☐ 16 to 30 minutes
- ☐ 31 to 45 minutes
- ☐ 46 minutes to 1 hour
- ☐ More than 1 hour, but less than 2 hours
- ☐ 2 hours or more

67. Please rate your experience with your children's health care during the past 12 months. If you have NO EXPERIENCE with a specific type of provider, please mark Not applicable.

For civilian providers? MARK ONE.

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Very good
- ☐ Excellent
- ☐ Not applicable

For military providers? MARK ONE.

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Very good
- ☐ Excellent
- ☐ Not applicable



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## SECTION IV: YOUR FAMILIARITY WITH MILITARY HEALTH CARE BENEFITS

This section asks about your familiarity with various aspects of your military health care benefit.

### 68. Do you know who to contact or where to get information about the following?

MARK ONE ANSWER FOR EACH ITEM.

	Yes, I know	No, I don't know	Does not apply
Health services and procedures available at Military Medical Treatment Facilities .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Charges for overnight stays at military hospitals .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Health services and procedures covered by CHAMPUS .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Charges for health services and procedures covered by CHAMPUS .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DEERS enrollment procedures .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When you need to obtain a Nonavailability Statement (NAS) .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Choice in selecting military doctors, clinics, and hospitals .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Choice in selecting civilian doctors, clinics, and hospitals .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHAMPUS claims filing procedures .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problems with a CHAMPUS claim .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Health benefits available after age 65 .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dental care available at Military Medical Treatment Facilities .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Active Duty Dependents Dental Plan (DDP★Delta) .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### 69. Are you or any family member covered by CHAMPUS?

- ☐ Yes —————→ **GO TO QUESTION 70.**  
☐ No —————→ **GO TO QUESTION 71.**  
☐ Not sure —————→ **GO TO QUESTION 71.**

### 70. How satisfied are you with the following aspects of your CHAMPUS benefits?

	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	Does not apply
Doctors' willingness to file CHAMPUS claims .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHAMPUS claims filing procedures .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Time it takes to solve claims problems .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Time waiting for payments from CHAMPUS .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Amount of CHAMPUS deductible .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Amount of CHAMPUS copayment .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Services and procedures covered by CHAMPUS .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ease of obtaining a Nonavailability Statement .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### 71. In general, how satisfied are you with your military health care benefit, considering both military care and CHAMPUS?

- ☐ Very satisfied  
☐ Satisfied  
☐ Neither satisfied nor dissatisfied  
☐ Dissatisfied  
☐ Very dissatisfied

## SECTION V: HEALTH AND DAILY ACTIVITIES

72. In general, would you say your health is:

- ☐ Excellent  
☐ Very good  
☐ Good  
☐ Fair  
☐ Poor

73. Compared to one year ago, how would you rate your health in general now?

- ☐ Much better now than one year ago  
☐ Somewhat better now than one year ago  
☐ About the same  
☐ Somewhat worse now than one year ago  
☐ Much worse now than one year ago

74. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. <u>Vigorous activities</u> , such as running, lifting heavy objects, participating in strenuous sports .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. <u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Lifting or carrying groceries .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Climbing <u>several</u> flights of stairs .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Climbing <u>one</u> flight of stairs .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Bending, kneeling, or stooping .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Walking <u>more than a mile</u> .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Walking <u>several blocks</u> .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Walking <u>one block</u> .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Bathing and dressing yourself .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

75. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (Please answer YES or NO for each question.)

	Yes	No
a. Cut down on the <u>amount of time</u> you spent on work or other activities .....	<input type="radio"/>	<input type="radio"/>
b. Accomplished <u>less</u> than you would like .....	<input type="radio"/>	<input type="radio"/>
c. Were limited in the <u>kind</u> of work or other activities .....	<input type="radio"/>	<input type="radio"/>
d. Had <u>difficulty</u> performing the work or other activities (for example, it took extra effort) .....	<input type="radio"/>	<input type="radio"/>

76. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? (Please answer YES or NO for each question.)

	Yes	No
a. Cut down on the <u>amount of time</u> you spent on work or other activities .....	<input type="radio"/>	<input type="radio"/>
b. Accomplished <u>less</u> than you would like .....	<input type="radio"/>	<input type="radio"/>
c. Didn't do work or other activities as <u>carefully</u> as usual .....	<input type="radio"/>	<input type="radio"/>



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77. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

78. How much bodily pain have you had during the past 4 weeks?

- ☐ None
- ☐ Very mild
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Very severe

79. During the past 4 weeks, how much did pain interfere with your normal work (including work both outside the home and housework)?

- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

80. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please indicate the one answer that comes closest to the way you have been feeling.

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
How much of the time during the <u>past 4 weeks</u> . . .						
a. did you feel full of pep? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. have you been a very nervous person? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. have you felt so down in the dumps nothing could cheer you up? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. have you felt calm and peaceful? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. did you have a lot of energy? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. have you felt downhearted and blue? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. did you feel worn out? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. have you been a happy person? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. did you feel tired? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

81. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

82. How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Not sure	Mostly false	Definitely false
a. I seem to get sick a little easier than other people. ....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I am as healthy as anybody I know. ....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I expect my health to get worse. ....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. My health is excellent. ....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## SECTION VI: INFORMATION ABOUT YOU

This final section asks for additional information about you. This information will be used to study differences in responses based on categories of beneficiaries. This will not be used to identify you personally.

87. What age were you on your last birthday?

(If you are 99 years old or older, mark "99")

Years

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

83. During the past 12 months, how many work/duty days did you miss due to your own illness or injury (do not include normal maternity visits or routine exams)?

- ☐ None  
☐ 1-2 days  
☐ 3-4 days  
☐ 5-6 days  
☐ 7-10 days  
☐ 11-20 days  
☐ 21-30 days  
☐ 31 days or more  
☐ Not applicable

84. Are you?

- ☐ Male → GO TO QUESTION 87.  
☐ Female

85. Have you been pregnant in the past 12 months?

- ☐ No → GO TO QUESTION 87.  
☐ Yes, but I am not currently pregnant  
☐ Yes, I am currently pregnant  
☐ I am not sure → GO TO QUESTION 87.

86. When did you first see a health care provider about your pregnancy?

- ☐ During first 3 months  
☐ During second 3 months  
☐ During last 3 months  
☐ During labor and delivery  
☐ Never

88a. Are you an active duty or retired service member?

- ☐ Yes, an active duty service member  
☐ Yes, a retired service member  
☐ No → GO TO QUESTION 89a.

88b. To which service do you belong or from which service did you retire? MARK ONE.

- ☐ Army  
☐ Air Force  
☐ Coast Guard  
☐ National Oceanic and Atmospheric Administration  
☐ Navy  
☐ Marine Corps  
☐ Public Health Service  
☐ Other (specify)

88c. What is your paygrade or what was your paygrade at retirement?

- ☐ E-1   ☐ E-8   ☐ O-1   ☐ O-8  
☐ E-2   ☐ E-9   ☐ O-2   ☐ O-9  
☐ E-3   ☐ W-1   ☐ O-3   ☐ O-10  
☐ E-4   ☐ W-2   ☐ O-4   ☐ Cadet/Midshipman  
☐ E-5   ☐ W-3   ☐ O-5   ☐ Not sure  
☐ E-6   ☐ W-4   ☐ O-6  
☐ E-7   ☐ W-5   ☐ O-7



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89a. Are you eligible for DoD health care benefits because you are a family member or survivor of an active duty or retired service member?

- ☐ Yes, I have eligibility from a sponsor who is active duty
- ☐ Yes, I have eligibility from a sponsor who is retired
- ☐ Yes, I have eligibility as a survivor of an active duty service member
- ☐ Yes, I have eligibility as a survivor of a retired service member
- ☐ No → **GO TO QUESTION 90.**

89b. To which service does/did your sponsor belong or from which service did your sponsor retire? **MARK ONE.**

- ☐ Army
- ☐ Air Force
- ☐ Coast Guard
- ☐ National Oceanic and Atmospheric Administration
- ☐ Navy
- ☐ Marine Corps
- ☐ Public Health Service
- ☐ Other (specify)

89c. What is your sponsor's paygrade or what was your sponsor's last paygrade?

- ☐ E-1    ☐ E-8    ☐ O-1    ☐ O-8
- ☐ E-2    ☐ E-9    ☐ O-2    ☐ O-9
- ☐ E-3    ☐ W-1    ☐ O-3    ☐ O-10
- ☐ E-4    ☐ W-2    ☐ O-4    ☐ Cadet/Midshipman
- ☐ E-5    ☐ W-3    ☐ O-5    ☐ Not sure
- ☐ E-6    ☐ W-4    ☐ O-6
- ☐ E-7    ☐ W-5    ☐ O-7

90. Which category best describes your eligibility for DoD health care benefits? **MARK ONE.**

- ☐ Active duty service member
- ☐ Family member of active duty service member
- ☐ Retired service member
- ☐ Family member of retired/deceased service member
- ☐ Other (specify)

91. Which of the following best describes your current marital status?

- ☐ Never married
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

92. What is the highest school grade or academic degree that you have?

- ☐ Less than 12 years of school (no diploma)
- ☐ GED or other high school equivalency certificate
- ☐ High school diploma
- ☐ Some college, but did not graduate
- ☐ 2-year college degree (AA/AS)
- ☐ 4-year college degree (BA/BS)
- ☐ Some graduate school, but no degree
- ☐ Master's, doctoral degree, or professional school degree (MA/MS/PhD/MD/JD/DVM)

93. Are you of Hispanic/Spanish origin or descent?

- ☐ No (not Spanish/Hispanic)
- ☐ Yes, Mexican, Mexican-Amer., Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic

94. What race do you consider yourself to be?

- ☐ White
- ☐ Black/African-Amer.
- ☐ Indian (Amer.)/Eskimo/Aleut
- ☐ Asian or Pacific Islander
- ☐ Other (specify)

95. How long have you lived in your current local area?

- ☐ Less than 6 months
- ☐ 6-12 months
- ☐ 1-3 years
- ☐ More than 3 years

96. What is the ZIPCODE, APO, or FPO where you now live?

ZIPCODE

0	0	0	0	0
1	1	1	1	1
2	2	2	2	2
3	3	3	3	3
4	4	4	4	4
5	5	5	5	5
6	6	6	6	6
7	7	7	7	7
8	8	8	8	8
9	9	9	9	9

- ☐ Does not apply; I do not have a ZIPCODE, APO, or FPO.

97. Mark the Military Medical Treatment Facility at which you received most of your medical care during the past 12 months. If you do not receive most of your care at a Military Medical Treatment Facility, mark the one that you would most likely use. (If you do not find the Facility you use or plan to use on the list, turn to page 22 and write it in the block.)

**ALABAMA**

- ☐ Fort McClellan
- ☐ Fort Rucker
- ☐ Maxwell Air Force Base
- ☐ Redstone Arsenal

**ALASKA**

- ☐ Branch Hospital, Adak
- ☐ Eileson Air Force Base
- ☐ Elmendorf Air Force Base
- ☐ Fort Wainwright

**ARIZONA**

- ☐ Davis Monthan Air Force Base
- ☐ Fort Huachuca
- ☐ Luke Air Force Base

**ARKANSAS**

- ☐ Little Rock Air Force Base

**CALIFORNIA**

- ☐ Beale Air Force Base
- ☐ Castle Air Force Base
- ☐ Edwards Air Force Base
- ☐ Fort Irwin
- ☐ Fort Ord
- ☐ Letterman Army Medical Center
- ☐ Los Angeles AFS
- ☐ March Air Force Base
- ☐ McClellan Air Force Base
- ☐ Naval Hospital, Camp Pendleton
- ☐ Naval Hospital, Lemoore
- ☐ Naval Hospital, Long Beach
- ☐ Naval Hospital, Twentynine Palms
- ☐ Naval Medical Center, Oakland
- ☐ Naval Medical Clinic, Port Hueneme
- ☐ Naval Medical Center, San Diego
- ☐ Travis Air Force Base
- ☐ Vandenberg Air Force Base

**COLORADO**

- ☐ Fitzsimons Army Medical Center
- ☐ Fort Carson
- ☐ Lowry Air Force Base
- ☐ Peterson Air Force Base
- ☐ USAF Academy

97. continued . . .

**CONNECTICUT**

- ☐ Naval Hospital, Groton

**DELAWARE**

- ☐ Dover Air Force Base

**DISTRICT OF COLUMBIA**

- ☐ Bolling Air Force Base
- ☐ Walter Reed Army Medical Center

**FLORIDA**

- ☐ Eglin Air Force Base
- ☐ MacDill Air Force Base
- ☐ Naval Hospital, Jacksonville
- ☐ Naval Hospital, Orlando
- ☐ Naval Hospital, Pensacola
- ☐ Naval Medical Clinic, Key West
- ☐ Patrick Air Force Base
- ☐ Tyndall Air Force Base

**GEORGIA**

- ☐ Fort Benning
- ☐ Fort Gordon
- ☐ Fort Stewart
- ☐ Moody Air Force Base
- ☐ Naval Medical Clinic - Kings Bay
- ☐ Robins Air Force Base

**HAWAII**

- ☐ Hickam Air Force Base
- ☐ Naval Medical Clinic, Pearl Harbor
- ☐ Tripler Army Medical Center

**IDAHO**

- ☐ Mountain Home Air Force Base

**ILLINOIS**

- ☐ Naval Hospital, Great Lakes
- ☐ Scott Air Force Base

**INDIANA**

- ☐ Grissom Air Force Base

**KANSAS**

- ☐ Fort Leavenworth
- ☐ Fort Riley
- ☐ McConnell Air Force Base

**KENTUCKY**

- ☐ Fort Campbell
- ☐ Fort Knox



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97. continued ...

**LOUISIANA**

- ☐ Barksdale Air Force Base
- ☐ Fort Polk
- ☐ Naval Medical Clinic, New Orleans

**MAINE**

- ☐ Loring Air Force Base
- ☐ Martin's Point - Portland

**MARYLAND**

- ☐ Andrews Air Force Base
- ☐ Fort Meade
- ☐ National Naval Medical Center, Bethesda
- ☐ Naval Hospital, Patuxent River
- ☐ Naval Medical Clinic, Annapolis
- ☐ Wyman Park, Baltimore

**MASSACHUSETTS**

- ☐ Brighton Marine USTF - Boston
- ☐ Fort Devens
- ☐ Hanscom Air Force Base

**MICHIGAN**

- ☐ K.I. Sawyer Air Force Base

**MISSISSIPPI**

- ☐ Columbus Air Force Base
- ☐ Keesler Air Force Base

**MISSOURI**

- ☐ Fort Leonard Wood
- ☐ Whiteman Air Force Base

**MONTANA**

- ☐ Malmstrom Air Force Base

**NEBRASKA**

- ☐ Offutt Air Force Base

**NEVADA**

- ☐ Nellis Air Force Base

**NEW HAMPSHIRE**

- ☐ Naval Medical Clinic, Portsmouth, N.H.

**NEW JERSEY**

- ☐ Fort Monmouth
- ☐ McGuire Air Force Base/Fort Dix

**NEW MEXICO**

- ☐ Cannon Air Force Base
- ☐ Holloman Air Force Base
- ☐ Kirtland Air Force Base

**NEW YORK**

- ☐ Bayley Seton - Staten Island
- ☐ Griffiss Air Force Base

97. continued ...

**NEW YORK**

- ☐ Plattsburgh Air Force Base
- ☐ West Point

**NORTH CAROLINA**

- ☐ Fort Bragg
- ☐ Naval Hospital, Camp Lejeune
- ☐ Naval Hospital, Cherry Point
- ☐ Pope Air Force Base
- ☐ Seymour Johnson Air Force Base

**NORTH DAKOTA**

- ☐ Grand Forks Air Force Base
- ☐ Minot Air Force Base

**OHIO**

- ☐ Lutheran Medical - Cleveland
- ☐ Wright-Patterson Air Force Base

**OKLAHOMA**

- ☐ Altus Air Force Base
- ☐ Fort Sill
- ☐ Tinker Air Force Base
- ☐ Vance Air Force Base

**PENNSYLVANIA**

- ☐ Naval Medical Clinic, Philadelphia

**RHODE ISLAND**

- ☐ Naval Hospital, Newport

**SOUTH CAROLINA**

- ☐ Charleston Air Force Base
- ☐ Fort Jackson
- ☐ Naval Hospital, Beaufort
- ☐ Naval Hospital, Charleston
- ☐ Shaw Air Force Base

**SOUTH DAKOTA**

- ☐ Ellsworth Air Force Base

**TENNESSEE**

- ☐ Naval Hospital, Millington

**TEXAS**

- ☐ Brooks Air Force Base
- ☐ Dyess Air Force Base
- ☐ Fort Bliss
- ☐ Fort Hood
- ☐ Fort Sam Houston
- ☐ Goodfellow Air Force Base
- ☐ Kelly Air Force Base
- ☐ Lackland Air Force Base
- ☐ Laughlin Air Force Base
- ☐ Naval Hospital, Corpus Christi
- ☐ Randolph Air Force Base
- ☐ Reese Air Force Base
- ☐ St. John's - Nassau Bay



Month	Day
<input type="radio"/> January	
<input type="radio"/> February	
<input type="radio"/> March	0 0
<input type="radio"/> April	1 1
<input type="radio"/> May	2 2
<input type="radio"/> June	3 3
<input type="radio"/> July	4
<input type="radio"/> August	5
<input type="radio"/> September	6
<input type="radio"/> October	7
<input type="radio"/> November	8
<input type="radio"/> December	9

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## Section VII. Comments

**Thank you very much for your cooperation in this important survey.**

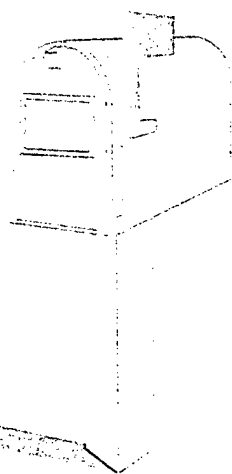
**We have attempted to be thorough in examining issues that are related to the health care you receive. If you have comments that may help us to better understand your experiences with the military health care system, please write them in the space below (continue on the back if necessary).**

**If your comments concern a particular question, be sure to write the question number before your comment.**

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

**Your cooperation in completing this survey is greatly appreciated.**

THANK YOU FOR COMPLETING THIS SURVEY!



PLEASE RETURN YOUR COMPLETED SURVEY IN THE  
BUSINESS REPLY ENVELOPE.

IF YOU ARE RETURNING THE SURVEY FROM ANOTHER  
COUNTRY, BE SURE TO RETURN THE BUSINESS REPLY  
ENVELOPE ONLY THROUGH A U.S. GOVERNMENT  
MAIL ROOM OR POST OFFICE.

FOREIGN POSTAL SYSTEMS WILL NOT DELIVER  
BUSINESS REPLY MAIL.



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